

Date: _____

Referring Physician: _____

Name: _____

Primary Physician: _____

Address: _____

Occupation: _____

City/State/Zip: _____

Height: _____

Phone: _____

Weight: _____

Reason for today's visit:					
Date of Injury/onset:					
Nature of Injury:		Sports <input type="checkbox"/>	Workman Comp <input type="checkbox"/>	MVA <input type="checkbox"/>	Other <input type="checkbox"/>
If sports, name of team/school:					
If MVA, state where accident occurred:					
If other, please explain:					
Describe your current symptoms and date of onset:					
Severity:	Mild <input type="checkbox"/>	Discomforting <input type="checkbox"/>	Distressing <input type="checkbox"/>	Horrible <input type="checkbox"/>	Excruciating <input type="checkbox"/>

Right or Left Knee		
Is the injury:	New	Old
Do you have:	Swelling	Giving Way
Can you bear weight?	Yes	No

Right or Left Shoulder		
Is the injury:	New	Old
Do you have:	Numbness	Tingling
	Weakness	Pain when throwing

Right or Left Foot / Ankle		
Do you have:	Pain	Swelling
Can you bear weight?	Yes	No

Right or Left Hip / Thigh / Lower Leg		
Do you have	Pain/burning down leg	Weakness
	Pain/burning down foot	

Right or Left Arm / Elbow / Hand / Wrist			
Do you have:	Numbness	Tingling	Swelling
	Weakness	Stiffness	Pain

	Back			Neck
Do you have pain in your:	Upper	Mid	Lower	

Have you had:	MRI	CT	MYELOGRAM	X-RAY	EMG
When					
Where:					

(Continued on other side)



2800 E. Ajo Way, Ste. 200
Tucson, Az. 85713

520-874-9000



Past medical problems:	
Past surgical history:	

List current medications:

List allergies (include medication, food, environmental) No Known Allergies

Do you (have you) smoke? Yes No Packs per day: _____ How many years: _____

How often do you drink alcoholic beverages? Never Occasionally Regularly

Medical problems in your immediate family (parents, grandparents, siblings):

Heart Disease Cancer Diabetes High Blood Pressure

Do you now or have you ever had the following?

Heart trouble/chest pain	Yes	No
Abnormal electrocardiogram	Yes	No
Stomach ulcers	Yes	No
Blood diseases (i.e., anemia)	Yes	No
Abnormal chest x-ray	Yes	No
Diabetes	Yes	No
Glaucoma	Yes	No
Abnormal bleeding tendencies	Yes	No
Lung Disease	Yes	No
Chronic bronchitis	Yes	No
Asthma	Yes	No
Emphysema	Yes	No

Anticoagulant therapy (blood thinners)	Yes	No
Blood vessel disease (phlebitis)	Yes	No
Kidney disease	Yes	No
Stroke	Yes	No
Epilepsy or seizures	Yes	No
Jaundice, hepatitis, mononucleosis	Yes	No
Cancer	Yes	No
High blood pressure	Yes	No
Thyroid disease	Yes	No
Positive HIV Test	Yes	No
Arthritis	Yes	No
Abnormal anesthetic reaction	Yes	No



2800 E. Ajo Way, Ste. 200
Tucson, Az. 85713

520-874-9000

