



NEW PATIENT

We appreciate you taking time to complete the following as accurately as possible.

NAME: _____ **DOB:** _____ **DATE:** _____

OCCUPATION: _____ **Are you Right-handed** **or Left-handed**

Is the injury due to a motor vehicle accident? yes no

Have you filed a work comp claim or accident report with your employer? yes no

Name of employer (only if work related) _____

Chief Complaint: What are we seeing you for today? *Right* *Left* _____

Is the injury sports related? yes no What sport(s) do you play? _____

Date of Injury: _____ **How did your symptoms begin?** _____

What makes your pain better? _____

What makes your pain worse? _____

Are your symptoms: Annoying Painful Intermittent Constant Numbness Tingling Achy Throbbing
 Burning Shooting Sharp Stabbing Other _____ (check all that apply)

Have you tried any of the following:

Physical Therapy If so where, when, how long? _____

Tylenol

Anti-inflammatories (examples: Ibuprofen, Aleve, Advil) _____

Prescription Medication _____

Topical Cream (examples: Aspercreame, Voltaren, Icy Hot) other _____

Have you had any prior treatment to this area? _____

*For the problem you are being evaluated for **TODAY**, have you had any of the following tests? (check all that apply)*

X-rays MRI Nerve Studies CT Scans When? _____ Where? _____

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? yes no maybe does not apply

ALLERGIES: No medication allergies **Are you allergic to Latex?** yes no

PLEASE LIST ALL **MEDICATION ALLERGIES** AND THE **REACTION** YOU HAVE:

PHARMACY NAME: _____

*****ONLY FILL OUT BACK SIDE IF YOUR PRIMARY DOCTOR IS NOT A MERCY DOCTOR*****

Medication Name – Over the counter and prescription	Dose/MG

Surgical History-Type of surgery	Date	Surgeon

Family History: Check all that apply

ADOPTED/UNKNOWN

	SELF	MOTHER <input type="checkbox"/> DECEASED	FATHER <input type="checkbox"/> DECEASED
Heart Disease			
High Blood Pressure			
Stroke			
Cancer			
Diabetes			
Asthma			
Seizures			
Bleeding Disorder			
Thyroid Disease			
Kidney Disease			
Mental Illness			
Other:			

SOCIAL HISTORY:

Are you married? Yes No

Do you live with someone that can help you? Yes No

Do you smoke or Vape? Yes No Packs per day _____

Former smoker - Date quit _____

Do you chew tobacco? Yes No

Have in the past - Date quit _____

Do you drink alcohol? Yes No

Drinks per week _____

Any history of drug or alcohol abuse? Yes No