New Patient Personal History

Date ________________ Social Security # ____________________ Birthday ______________ Age _________

Name ____ Address _____________________________________

City __________________ State _______________________ Zip ___________ Home Phone (____) ____________

Cell Phone (____) ____________________ Work Phone (____) ____________________

E-mail address ______________________________________ Occupation ____________________________

Driver's License # ____ Employer & location (city) ________________________

Name of Spouse ____
(First) (Middle) (Last)

Check One ☐ Married ☐ Single ☐ Widowed ☐ Separated # of Children _________

Name of Emergency Contact ___________________________ Phone (____) ____________________

History / Chief Complaint Checklist:

Last visit to Family Doctor: ___________________________________
Last visit to any Health Care Practitioner (Gyn., Nurse Practitioner, etc.): _______________________
Last visit to Dentist: __________________________

Are you pregnant? Yes ☐ No ☐

Have you told other doctors about these complaints? Yes ☐ No ☐

What did they do about it? ____

Did it help? Yes ☐ No ☐

How long have you felt pain or problems with this episode?
______ Days ______ Weeks

Did it come on gradually? ______________________

What was the "Incident" or circumstance? ____

What does the pain or problem effect? Check all that apply:
Work Performance: _________ Home Activities: ___________ Recreational Activities: __________
Child care: ________ Mood: ________ Overall Performance: ___________

Are you taking medications? Ibuprofen Aspirin Pain Reliever Prescription
____

Have you used: _____ Ice _____ Heat ________ Stretching ________ Massage

What makes it worse: ____

What helps: ____

Daily Activity - Recent History:

Do you lift a lot: Yes ☐ No ☐ Are you on the computer a lot: Yes ☐ No ☐
Do you sit a lot: Yes ☐ No ☐ Do you drive a lot: Yes ☐ No ☐
Do you have young children that you have to lift?: Yes ☐ No ☐

Do you play sports?: ____________________________________

Is the pain worse: in the morning ☐ afternoon ☐ evening ☐ all day ☐ Late night / Sleeping ☐

Any procedures or Operations? ____

Broken Bones? ____

Other Reasons for Pain: ____

Patient's Signature X ____________________________________ Date _______________________
(Signature Authorizing Care)

Today's Date:________________________

Your First Name:__________________________ MI:________ Last Name:____________________

X all that apply and put L = Left, R = Right, B = Both

Area of Pain:

Headache ________
Face Pain ________
Jaw Pain ________
Neck Pain ________
Shoulder ________
Arm Pain ________
Elbow ________
Wrist ________
Hand ________
Upper Back ________
Mid Back ________
Chest ________
Ribs ________
Low Back ________
Hips ________
Leg (s) ________
Knee ________
Ankle ________
Foot ________

Character of Symptoms:

Sore _______
Stiff _______
Tight _______
Ache _______
Cramping _______
Fatigue _______
Spasm _______
Sharp Pain _______
Tension _______
Radiating _______
Shooting _______
Burning _______
Dull Pain _______
Pain is in Spot _______
Pain is over area _______
Deep Pain _______
Tingling _______
Numbness _______

Pain Level:

Overall / All Together =_____________

0= No Pain - 10 = Unbearable

Pain Frequency:

What percent of Day?
Day: _______ %

Functional Deficit: I feel ________ % functional.

Fear Avoidance Behaviors:
I avoid activities due to fear of pain or injury
Yes ☐ No ☐

Other: ____

Indicate Ability To Perform The Following Activities

Use codes : U - Unable P - Pain D - Difficult L - Limited N - Normal

Coughing or Sneezing _______
Kneeling _______
Balancing _______
Turning over in bed _______
Walking a short distance _______
Standing for more than 1hour _______
Sitting _______
Lying on back _______
lying flat on stomach _______
Knees bent _______
House work _______
Yard work _______
Childcare _______
Playing with kids _______
Work duties _______
Walking dog _______

Climbing _______
Getting out of the car _______
Bending _______
Getting dressed _______
Sleeping _______
Stooping _______
Gripping _______
Pushing _______
Pulling _______
Reaching _______
Bending _______
Lifting _______
Twisting _______
Moving from sit to stand _______
Driving _______
Sexual activity _______

Stairs _____
Keyboarding _____
Mousing _____
One position too long _____

Any other Comments or Considerations:

____

____

Patient Name(Print) ______________________________ Date ____________

Patient ID # ____________

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping

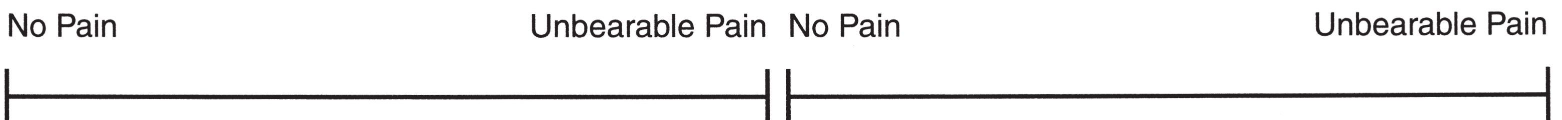
On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain — Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain — Unbearable Pain



Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain