Details of Accident or Onset of Symptoms/Illness

Primary Care Provider Name: _____

Primary Care Provider Address: _____

Primary Care Provider Phone: _____

Date of accident or symptoms: _____/_____/_____ **What body area was injured?** _____

Where were you injured?

Work related:	☐ Yes	☐ No
Auto accident:	☐ Yes	☐ No
School:	☐ Yes	☐ No
Home:	☐ Yes	☐ No

Explain occurrence of injury or symptoms:

_____

_____

_____

Accident location (if not at home): _____

_____

Have you had this kind of injury before? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Surgeries

(Type & Date)

_____

_____

_____

Social History

What type of work do you do? _____

Current work status? ☐ Full duty ☐ Limited duty ☐ Disabled

Tobacco products per day? _____ **Alcoholic beverages per day?** _____

History of substance abuse? ☐ Yes ☐ No **If yes, list drugs taken:** _____

Dominant hand? ☐ Right ☐ Left Height: ___(ft) ____(in) Weight: _____lbs

Medications

Please list your medications and dosages you are taking now. Please include all over the counter medications, vitamins and/or herbs.

_____

_____

Please list the name and address of your preferred pharmacy: _____

Do you have a pain management physician? ☐ Yes ☐ No

If yes, name and phone number of MD: _____

Allergies

List any allergies to medications: _____

_____

_____

_____

Other allergies (i.e.: latex, adhesive bandages, topical medications, etc): _____

_____

Review of Systems

Do you have or have you ever had any of the following conditions?

AIDS: ☐ Yes ☐ No
Asthma: ☐ Yes ☐ No
Bleeding Disorder: ☐ Yes ☐ No
Cancer: ☐ Yes ☐ No
COPD: ☐ Yes ☐ No
Dementia: ☐ Yes ☐ No
Diabetes Type I: ☐ Yes ☐ No
Diabetes Type II : ☐ Yes ☐ No
Epilepsy: ☐ Yes ☐ No
Hepatitis: ☐ Yes ☐ No
High Blood Pressure or Hypertension: ☐ Yes ☐ No
Heart Problems: ☐ Yes ☐ No

If yes, then:
Cardiologist name: _____
Cardia Catherization: ☐ Yes ☐ No
Echocardiogram: ☐ Yes ☐ No
Open Heart Surgery: ☐ Yes ☐ No
Pacemaker: ☐ Yes ☐ No
Stents:
Stress Test:
Date of Heart Procedure: _____/_____/_____
Location of Heart Procedure: _____

Kidney Disorder: ☐ Yes ☐ No
Oxygen Use: ☐ Yes ☐ No
Sleep Apnea: ☐ Yes ☐ No

If YES, then:
Date & place of last sleep study: _____
Do you use a c-pap : ☐ Yes ☐ No

Thyroid Disorder: ☐ Yes ☐ No

Family History

List any of your family members who have had the above problems and which specific problem they have had: (to include father, mother, children, siblings and grandparents):

_____

_____

_____

_____	_____	_____
Print Name	**Signature**	**Date**