

Goldman



HT: _____
WT: _____

Name _____ Occupation _____

Date ____/____/____ Age _____ Male _____ Female _____

Athletic Activities: Yes _____ No _____

If yes, please list activities: _____

Competitive Level: professional _____ amateur (daily) _____ amateur (3-5x/wk) _____ seldom _____ never _____

Visit Information:

Referral: Yes _____ No _____ Name of referring physician _____

Workers Comp Case: Yes _____ No _____

Date of Injury: ____/____/____ (please give approximate date if unknown)

Please describe the injury or onset of this problem _____

About your injury/problem: (please check all affected areas)

<input type="checkbox"/> Neck	<input type="checkbox"/> Upper back	<input type="checkbox"/> Forearm	<input type="checkbox"/> Chest	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Knee
<input type="checkbox"/> Elbow	<input type="checkbox"/> Lower back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hand	<input type="checkbox"/> Finger	<input type="checkbox"/> Hip
<input type="checkbox"/> Thigh	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Calf	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Toe

Side Affected: Right Left Both

Dominant Arm: Right Left

Please check significant symptoms of pain:

<input type="checkbox"/> Aching	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Burning	<input type="checkbox"/> Dull	<input type="checkbox"/> Periodic
<input type="checkbox"/> Sharp	<input type="checkbox"/> Spasmodic	<input type="checkbox"/> After Activity	<input type="checkbox"/> Unknown Cause	<input type="checkbox"/> Radiating

Other types of symptoms:

<input type="checkbox"/> Discomfort	<input type="checkbox"/> Numbness	<input type="checkbox"/> Giving out	<input type="checkbox"/> Popping
<input type="checkbox"/> Stiffness	<input type="checkbox"/> Tingling	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Grinding
<input type="checkbox"/> Soreness	<input type="checkbox"/> Tenderness	<input type="checkbox"/> Instability	<input type="checkbox"/> Swelling

Have you seen other physicians for this problem? _____ If yes, list date & name _____

Treatment for problem _____

Physical Therapy? Yes No Cortisone Injections? Yes No

List medications/dosages you are currently taking _____

Are you being treated for other health problems? Please explain _____

Please list any drug allergies: _____

Family History:	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes
Personal History:	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes

Do you smoke cigarettes, cigars, or a pipe? Yes No _____ Packs per day Chew? Y N

Drink alcohol/beer? Yes No

Do you ever have shortness of breath? Yes No Ever have chest pain? Yes No

Please list any previous surgeries, hospitalizations, serious injuries or accidents _____