

EMG/HIP INJ PATIENT HISTORY FORM

Primary Physician _____ Referring physician: _____ (FIRST/LAST NAME) *BP: _____ PULSE _____ *
 FOR OFFICE USE ONLY
 What is your pain scale 0-10? (10 being severe) _____

Name: _____ DOB: _____ Age: _____ Height: _____ Weight: _____
 Date of Injury/when symptoms began? _____ Body part affected _____ left/right (circle)
 Is this work related? _____ If yes, have you filed a worker's compensation claim? Yes No
 What activity were you performing at the time your symptoms began? _____
 What, if anything, makes your symptoms better? _____
 What, if anything, makes your symptoms worse? _____

Have you been treated by another physician, chiropractor, or therapist for this condition? (If yes, please explain) _____

Have you had any of the following exams in regards to this injury?

	Circle Yes or No		when/where		Circle Yes or No		when/where
Xray	Yes	No	_____	Arthrogram	Yes	No	_____
MRI	Yes	No	_____	Myelogram	Yes	No	_____
CT	Yes	No	_____	EMG	Yes	No	_____

Check any medical conditions you or your immediate family have now or have had in the past.

	Self	Family		Self	Family		Self	Family
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Gastric Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Hyper/Hypothyroid	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver dz	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vascular dz	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Specify type of cancer	_____	

List any previous surgeries/hospitalizations: _____

List current medications (or attach list): _____

List allergies and drug reactions: _____

Occupation: _____ **Living arrangements:** (i.e. alone, with child, etc) _____

Do you smoke? (Circle one) Yes No How many packs per day? _____ How many years? _____

Do you consume alcohol? (Circle one) Yes No How many drinks per week? _____

Do you use recreational drugs? (Circle one) Yes No Type of drug(s): _____

REVIEW OF SYSTEMS: Please check if you have experienced or are experiencing any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Constant Fatigue | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Frequent diarrhea |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Chronic cough(s) | <input type="checkbox"/> Urinary frequency |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Recurrent Nose bleeds | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Chill | <input type="checkbox"/> Bruising | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Shortness of breath with exertion | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Nail changes | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nausea | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blood in Stool | |

Patient Signature _____ **Date** _____ **Physician Initial** _____