Today's Date_____

Name: _____Preferred Name:_____ Date of Birth: _____

Occupation: _____ ☐ Married ☐ Single ☐ Widowed ☐ Male ☐ Female ☐_____

Tobacco Use: ☐ None ☐ Yes- # of years: _____ ☐ Former-Date Quit:_____ Alcohol use? **Y/N** Dominant Hand **R/L**

Any falls in the last year? ☐ Yes ☐ No How Many? _____ Have any falls resulted in injury? ☐ Yes ☐ No

Primary Care Physician_____ Referring physician_____

We may use a secure, HIPAA-protected AI tool to help draft notes from your visit. Your doctor reviews and approves every note.
☐ I acknowledge the use of AI-assisted documentation ☐ I prefer it **not** be used during my visits

Review of Systems

☐ fatigue
☐ unexplained weight loss
☐ Fever
☐ easy bleeding/bruising
☐ visual changes

☐ chest pain
☐ abdominal pain
☐ edema/swelling
☐ Headaches

☐ Dizziness
☐ Gait changes
☐ balance changes

☐ extremity pain
☐ Joint pain
☐ back pain
☐ neck pain
☐ urinary incontinence
☐ bowel incontinence

☐ Sudden change in bowel/bladder function

☐ extremity weakness (circle one) arms/ legs/ both

☐ Extremity numbness: intermittent/ constant/ progressive

Your Medical History

☐ Alzheimer's/dementia
☐ arthritis
☐ cardiac arrythmia/atrial fib
☐ heart failure
☐ depression
☐ anxiety
☐ diabetes
  ☐ non-insulin dependent
  ☐ insulin dependent
☐ high cholesterol
☐ Gastric/stomach ulcers

☐ fibromyalgia
☐ head injury
☐ headaches: migraine/ tension
☐ hepatitis
☐ liver disease
☐ hypertension
☐ osteoporosis
☐ Osteopenia
☐ HIV/ AIDS
☐ Cancer
type/ status:_____

☐ parkinson disease
☐ Neuropathy
☐ polio
☐ renal disease/ kidney disease
☐ seizure disorder
type/status:_____
☐ stroke
☐ thyroid disease / disorder
☐ tremor
☐ other
_____

Your Surgical History
(please write date next to entry)

☐ heart SURGERY:

_____
stent/cabg/valve/pacemaker

☐ arthroscopy: _____

☐ knee/hip/shoulder: _____

☐ carpal tunnel SURGERY _____

☐ Cubital tunnel SURGERY _____

☐ gastric bypass _____

☐ hip replacement R / L _____

☐ knee replacement R / L _____

☐ cervical (neck) surgery _____

☐ lumbar (back) surgery _____

☐ spinal cord stimulator _____

☐ other_____

Name: _____ Date of Birth: _____

Regarding the problem that you are here to see the doctor for:

IF YOU HAVE PAIN, WHERE IS IT WORST?

WAS IT CAUSED BY A SPECIFIC INCIDENT OR ACCIDENT?

APPROXIMATELY WHEN DID YOUR SYMPTOMS START?

OVERALL, IS YOUR PAIN THE SAME, BETTER OR WORSE THAN IT BEGAN?

IF YOU HAVE PAIN, DO SYMPTOMS RADIATE OR MOVE ELSEWHERE? IF SO, WHERE?

WHAT MAKES THE SYMPTOMS WORSE?

WHAT MAKES THE SYMPTOMS BETTER?

HAVE YOU EVER HAD A NERVE AND MUSCLE TEST (EMG/ELECTROMYOGRAM) BEFORE? IF SO, WHEN AND WHERE?

WHAT CONSERVATIVE TREATMENTS HAVE BEEN TRIED <u>FOR THIS PROBLEM</u>:

⬜ OVER THE COUNTER PAIN RELIEVERS (NSAIDS, TYPE)
⬜ TOPICAL MEDICATION
⬜ ICE OR HEAT
⬜ SPLINTS/BRACES/WALKER
⬜ HOME EXERCISE PROGRAM
⬜ CHIROPRACTIC CARE
⬜ ACUPUNCTURE/MASSAGE
⬜ ACTIVITY MODIFICATION

FOR HOW MANY WEEKS DID YOU TRY THESE CONSERVATIVE TREATMENTS?
_____

⬜ PHYSICAL THERAPY WHERE? _____ WHEN/FOR HOW LONG?
_____

⬜ INJECTION(S) WHERE? _____ WHEN?
_____

⬜ RECENT IMAGING WHERE?