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Patient name______________________________ Age___________ Date ______________

Employer/School_________________________ Position/Grade____________________________

Problem

Current Problem? ____
____
____

Date this problem started____

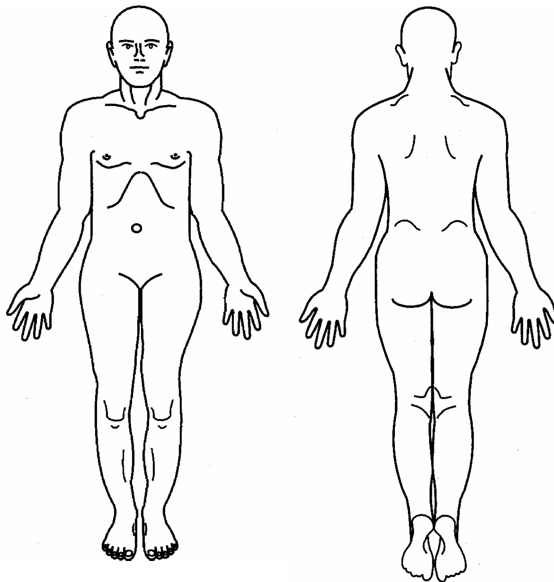
Is this work related? __________

How did problem occur/start______________________________________
____
____

Treatments you have received for this problem ____________________
____
____

Seen in ER?(if yes name)__________ X-Rays/MRI Taken?(where)_______
Auto Accident?________ Pending litigation?_________
Who referred you to our office____________________________________

Mark Injury Location



Name____________________ Date____________

Surgical History (any surgery, not just orthopedic surgery)

Problem + Date or Age	***Treatments + Doctor***	**Successful (Y/N)**

Medical History Height_______ Weight_______

Are you pregnant?_______________

List any current or past medical problems (dates and Doctors)

____
____
____
____
____

Current Medications (Prescription, Over the Counter, Herbal health products,vitamins, or dietary supplements)

	Name	**Dose**	**Frequency**		**Name**	**Dose**	**Frequency**
1.				**6.**			
2.				**7.**			
3.				**8.**			
4.				**9.**			
5.				**10.**			

All Medications written and called in from this office will be done so during normal business hrs (8am-5pm) Mon-Fri. Please contact the pharmacy first when requesting a new prescription or prescription refill. Please give our office 24 hours to refill your prescription.

Allergies to MEDICATIONS (list medication and reaction)

____
____
____

How often do you smoke (packs per day) ___________________________
How often do you drink alcohol (glasses per week) __________________
How often do you use recreational drugs (per week) _________________

Family Physician ____

Thank you for filling out this form