EST PATIENT-NEW PROBLEM

Chief Complaint

Dominant hand:

☐ Right hand ☐ Left Hand ☐ Ambidextrous

Description of the symptoms (select only one)

☐ Pain ☐ Numbness/Tingling ☐ Fracture ☐ Stiffness Other:

Shoulder	☐ Right	☐ Left	Pelvis	☐ Right	☐ Left	Neck	☐
Upper Arm	☐ Right	☐ Left	Hip	☐ Right	☐ Left	Upper Back	☐
Elbow	☐ Right	☐ Left	Thigh	☐ Right	☐ Left	Mid Back	☐
Forearm	☐ Right	☐ Left	Knee	☐ Right	☐ Left	Low Back	☐
Wrist	☐ Right	☐ Left	Lower Leg	☐ Right	☐ Left	Buttocks	☐
Hand	☐ Right	☐ Left	Ankle	☐ Right	☐ Left	Tail Bone	☐
Thumb	☐ Right	☐ Left	Foot	☐ Right	☐ Left		
Index	☐ Right	☐ Left	Great Toe	☐ Right	☐ Left		
Middle	☐ Right	☐ Left	2nd Digit	☐ Right	☐ Left		
Ring	☐ Right	☐ Left	3rd Digit	☐ Right	☐ Left		
Pinky	☐ Right	☐ Left	4th Digit	☐ Right	☐ Left		
			5th Digit	☐ Right	☐ Left		

History of Present Illness

1. Is your problem the result of an injury or accident?

☐ No Injury ☐ Injury ☐ Injury at Work ☐ Auto Accident ☐ Sport Injury ☐ Prior Surgery

2. Are you represented by an attorney? ☐ Yes ☐ No

3. Have you had a problem like this before? ☐ Yes ☐ No

4. Have you been seen in ER? ☐ Yes ☐ No

5. Rate the pain (10 being the most pain).

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

6. Do the symptoms wake you from your sleep? ☐ Yes ☐ No

7. Please describe the symptoms.

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing
☐ Aching ☐ Burning ☐ Shooting

8. What is the timing of the symptoms?

☐ Constant ☐ Intermittent (comes & goes)

9. Is the problem getting better or worse?

☐ Getting better ☐ Getting worse ☐ Unchanged

10. What makes the symptoms worse?

☐Squatting ☐Kneeling ☐Sitting ☐Bending ☐Stairs ☐Twisting
☐Moving ☐Lying in Bed ☐Running ☐Walking ☐Athletics ☐Standing
☐Gripping ☐Lifting ☐Reaching Overhead

11. Are there any other symptoms associated to this problem:

☐Redness ☐Bruising ☐Swelling ☐Numbness ☐Stiffness ☐Limping
☐Clicking ☐Locking ☐Popping ☐Tingling ☐Weakness ☐Giving way

Staff Enter History (Please type full sentences)

Prior Treatment / Testing

Did you have any prior tests?

☐None ☐X-rays ☐MRI ☐CAT Scan ☐Bone Scan ☐Nerve Test (EMG)

Did you have any prior treatments for this problem? ☐Yes ☐No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months? ☐None for all

				NONE	Comments
1) CON	☐Weight Loss	☐Loss of Appetite	☐Fatigue	☐	
2) EYE	☐Blurred Vision	☐Double Vision	☐Vision Loss	☐	
3) ENT	☐Hearing Loss	☐Hoarseness	☐Trouble Swallowing	☐	
4) CARDIO	☐Chest Pain	☐Palpitations		☐	
5) RESP	☐Chronic Cough	☐Pneumonia	☐Shortness of Breath	☐	
6) GI	☐Heartburn, Ulcers	☐Nausea, Vomiting	☐Blood in Stool	☐	
7) GU	☐Painful Urination	☐Blood in Urine	☐Kidney Problems	☐	
8) SKIN	☐Frequent Rashes	☐Skin Ulcers	☐Lumps ☐Psoriasis	☐	
9) NEURO	☐Frequent Falls	☐Loss of Coordination	☐Numbness	☐	
	☐Change in bowel	☐Change in bladder	☐Dizziness		
10) PSYCH	☐Depression/Anxiety	☐Drug/Alcohol Addiction	☐Sleep Disorder	☐	
11) ENDO	☐Fever	☐Heat or Cold Intolerance	☐Night Sweats	☐	
12) HEM	☐Easy Bleeding	☐Easy Bruising	☐Anemia	☐	

Medical Questions

☐Metal in body ☐Claustrophobic ☐Pregnant
☐Sleep Apnea ☐Use a C PAP ☐Snores

Is the patient taking blood thinners? ☐Yes ☐No

FAMILY HISTORY:

Please list any new medical conditions you parents or siblings have been diagnosed with:

SURGICAL HISTORY
Please list any new surgeries or hospitalizations since your last visit:

Enter all information into the Medical Information Tab

Plese list any new allergies you have developed since your last visit: ☐ None
Please include allergy and reaction.

Please list any changes to the medications you take, since your last visit: ☐ NONE
Please include Medication Name and Dosage.

Please list any changes to the supplements you take, since the last visit: ☐ NONE
Please include Supplement Name and Dosage.

Please list any new medical conditions you have been diagnosed with, since your last visit:
☐ NONE

SOCIAL HISTORY

1. Do you smoke tobacco? ☐ Daily ☐ Occasionally ☐ Former Smoker ☐ Never

2. Do you drink alcohol? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

3. Marital History: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership

4. Are you currently working? ☐ Yes ☐ No ☐ Retired ☐ Disabled

Occupation: Employer: ☐ **Student**