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DATE OF SERVICE: _____

PHYSICIAN/PA: Dr. Brett Krepps Dr. Mario Lee Dr. Gregory Woods Van LaMore, PA

PATIENT NAME		DOB
PRIMARY CARE PHYSICIAN	WERE YOU REFERRED? <input type="checkbox"/> No <input type="checkbox"/> Yes – By Whom _____	

What is the reason for this visit? Injury Pain Numbness Mass Other: _____

Where is the problem? Right Left Area of Body: _____

When did the problem begin? _____

How did the problem start? No Specific Injury Sports Fall Car Accident
 Work Related

Please explain: _____

What kind of pain do you feel? Sharp Dull Burning Throbbing Aching None

How severe are the symptoms? Mild Moderate Severe

How often do the symptoms occur? Intermittent (on and off) Constant
 When Sleeping At Night

What makes the symptoms worse? Exercise Lifting Pressure Driving Writing
 Gripping Computers Opening Jars Other _____

Since the problem started, it is: Getting Better Not Improving Getting Worse

The symptoms also include: Pain Weakness Swelling Stiffness
 Numbness/Tingling Instability Locking Catching

Which treatments have you tried?

<input type="checkbox"/> Rest	Improvement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Medications (which ones?) _____	Improvement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Splint (what kind?) _____	Improvement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Therapy (how long?) _____	Improvement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Injection (how many?) _____	Improvement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Surgery (what and when?) _____	Improvement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Tests taken for current problems:

X-ray MRI CT Scan Bone Scan Nerve Conduction
 Bone Density Ultrasound / Doppler Blood or Other Lab Tests _____

Have You Had Any of These Problems In the Last Six (6) Months? (Check all that apply.)

CONSTITUTIONAL

- Chills? No Yes
- Fatigue? No Yes
- Fever? No Yes
- Night Sweats? No Yes

HEAD, EYE, EAR, NOSE, THROAT

- Difficulty swallowing? No Yes
- Nose Bleeds? No Yes
- Facial Pain? No Yes
- Headaches? No Yes
- Hearing loss? No Yes
- Hoarseness? No Yes
- Nasal congestion? No Yes
- Ear pain/ earache? No Yes
- Ringing in your ears? No Yes
- Sinusitis? No Yes
- Sore throat? No Yes
- Dizziness / vertigo? No Yes
- Vision loss? No Yes

RESPIRATORY

- Cough? No Yes
- Shortness of breath? No Yes
- Recent infection? No Yes
- Wheezing? No Yes

CARDIOVASCULAR

- Chest pain? No Yes
- Have to sleep sitting up? No Yes
- Irregular heartbeat/palpitations? No Yes
- Swelling of legs? No Yes
- Episodes of fainting? No Yes

GASTROINTESTINAL

- Constipation? No Yes
- Diarrhea? No Yes
- Indigestion / Heartburn? No Yes
- Nausea? No Yes
- Vomiting? No Yes

GENITOURINARY

- Painful / burning urination? No Yes
- Frequent urination? No Yes
- Blood in urine? No Yes
- Have to go urgently? No Yes
- Lose control of bladder? No Yes

SKIN

- Rash? No Yes
- Skin infection? No Yes
- Skin lesion? No Yes

NEUROLOGICAL

- Difficulty walking? No Yes
- Lightheadedness / dizziness? No Yes
- Numbness/ tingling? No Yes
- Seizures? No Yes
- Tremors? No Yes

MUSCULOSKELETAL

- Back pain? No Yes
- Bone / joint pain? No Yes
- Muscle weakness? No Yes
- Muscle pain? No Yes

ENDOCRINE

- Cold intolerance? No Yes
- Heat intolerance? No Yes
- Weight gain? No Yes
- Weight loss? No Yes

PSYCHIATRIC

- Anxiety? No Yes
- Depression? No Yes
- Insomnia? No Yes

HEMATOLOGIC

- Easy bleeding? No Yes
- Easy bruising? No Yes
- Blood clots? No Yes

IMMUNOLOGICAL

- Asthma? No Yes

MEDICAL HISTORY: Have you **ever** had or do you **now** have any of the following? **None / Healthy**

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Angina | <input type="checkbox"/> COPD/ Emphysema | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Parkinson Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> DVT/ Blood clot | <input type="checkbox"/> Migraines | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Myocardial infarction/MI | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> GERD/ Acid Reflux | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Thyroid Disease |

Other _____

SURGICAL HISTORY (Please check the types of surgery you have had and write the approximate year the surgery was performed.) None **R- Right L- Left B- Both**

SURGERY			YEAR	SURGERY			YEAR
<input type="checkbox"/>	ACL surgery - R / L			<input type="checkbox"/>	Knee Replacement R / L		
<input type="checkbox"/>	Angioplasty / Heart			<input type="checkbox"/>	Laminectomy		
<input type="checkbox"/>	Appendix			<input type="checkbox"/>	Discectomy		
<input type="checkbox"/>	Arthroscopy knee R / L			<input type="checkbox"/>	Pacemaker		
<input type="checkbox"/>	Arthroscopy shoulder R / L			<input type="checkbox"/>	Rotator Cuff Repair R / L		
<input type="checkbox"/>	Back (disc or fusion)			<input type="checkbox"/>	Thyroids		
<input type="checkbox"/>	Bone / Fracture Repair			<input type="checkbox"/>	Tonsils / Adenoids		
<input type="checkbox"/>	CABG / bypass surgery			<input type="checkbox"/>	C-Section		
<input type="checkbox"/>	Carpal Tunnel R / L			<input type="checkbox"/>	Hysterectomy		
<input type="checkbox"/>	Cataract surgery			<input type="checkbox"/>	Breast /mastectomy R / L		
<input type="checkbox"/>	Gallbladder			<input type="checkbox"/>	Blood Vessels		
<input type="checkbox"/>	Colon / Bowel / Intestinal			<input type="checkbox"/>	Ovary / Tube		
<input type="checkbox"/>	Gastric Bypass			<input type="checkbox"/>	Prostate / Bladder		
<input type="checkbox"/>	Hernia			<input type="checkbox"/>	Kidney		
<input type="checkbox"/>	Hip Replacement R / L			<input type="checkbox"/>	Lung		
							YEAR
Other Surgery:							
Other Surgery:							

MEDICATIONS (Please list your current medications.) None

ALLERGIES TO MEDICATIONS None Known

- Aspirin Penicillin Other: _____
 Codeine Sulfa Latex

FAMILY HISTORY (What runs in your family?) None

- Cancer Gout Kidney Disease Arthritis
 Diabetes Heart Disease Liver Disease Osteoporosis

SOCIAL HISTORY Right Handed Left Handed Ambidextrous

SMOKING: No Yes If yes, packs per day? _____ Years smoking? _____ Quit, year _____

ALCOHOL: None Socially Rarely Occasionally Yearly Weekly Daily

MARITAL STATUS: Single Married Divorced Separated Widowed

CHILDREN: No Yes Number of sons: _____ Number of daughters: _____

HOBBIES OR SPORTS: _____

OCCUPATION: _____

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE PROVIDED IS ACCURATE.

 Patient's/ Legal Guardian Signature Date: _____

 Physician's Signature Date: _____