Patient's Name				Birth Date _____/_____/_____
Height	Weight	Shoe Size	Smoker? Y/N _____years Former Smoker? Y / N	Drink Alcohol? Y / N If yes _____drinks/week

Allergies (Circle all that apply) Check here if none ____

Aspirin /Anti-Inflammatory Medication /Codeine / Iodine / Local anesthetics / Metal (Nickel)/Penicillin / Sulfa / Tape

Other:

Reason for Evaluation/Treatment

Location of problem	How long?	Prior Treatment? Y / N By Dr._____

Past Surgical History (please list all surgeries below) Check here if none_____

Primary Care Physician Check here if none_____

Name	Phone # ( )

Check/Circle all those that apply either PAST or PRESENT Check here if none _____

- ☐ Artificial joints
- ☐ Asthma
- ☐ Cancer (type_____)
- ☐ Chemotherapy
- ☐ Cholesterol
- ☐ Circulation problems in legs
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart problems (attack/chest pains/murmur/irregular beat/congestive heart failure/mitral valve prolapse/valve disease)
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney problems (infections/stones/failure/dialysis)
- ☐ Liver problems
- ☐ Lung /breathing problems
- ☐ Neurological disorders
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Prostate problems
- ☐ Psoriasis/Eczema
- ☐ Rheumatoid arthritis
- ☐ Stomach/Intestine(ulcer/ acid reflux)
- ☐ Stroke
- ☐ Substance Abuse (street drugs/prescription drugs/alcohol)
- ☐ Thyroid disease
- ☐ Ulcers (diabetic)
- ☐ Varicose veins
- ☐ Other - Please list below

Patient/Guardian Signature	Date