	Instructio	ons	PLEAS	SE PRINT PATIEN					
Please use a #2 pencil. Fill in the complete oval	as shown	•		SE PRINT PATIEN		PAI	TENT'S DATE OF B	Year	
What is your email a	ddress?								_
Reason for today's vi	sit:								_
Type of problem									_
fracture	pai (broken bone	n 🔵 e) 🔵		sprain / strai swelling (new			ıkness 🔵 ngling 🔵	othe	r 🔿
Location of your inju	•								
collar bone	right	left	bilateral		hip	right	left	bilateral	
shoulder	0	$\overline{\mathbf{O}}$	$\overline{\mathbf{O}}$		thigh			$\overline{\mathbf{O}}$	
upper arm	\bigcirc	\bigcirc	\bigcirc		knee	\bigcirc	\bigcirc	\bigcirc	
elbow	\bigcirc	\bigcirc	\bigcirc		lower leg		\bigcirc	0	
lower arm wrist	\bigcirc	\bigcirc	\bigcirc		ankle foot		\bigcirc	\bigcirc	
hand	\bigcirc	\bigcirc			toes			\bigcirc	
fingers	$\overline{\mathbf{O}}$	$\overline{\mathbf{O}}$	$\overline{\mathbf{O}}$		back pain	\sim	$\overline{\mathbf{O}}$	$\overline{\mathbf{O}}$	
pelvis	\bigcirc	\bigcirc	\bigcirc		neck pain		\bigcirc	\bigcirc	
Other									_
PAIN INFORMATI	ON								
Is the pain:	occasiona		0	ntinuous 🔿	n/a	\bigcirc			
Is the pain:	improvin			orsening O	unchanged		comes and go	es 🔵 n/a	
Is the pain:		p 🔿		dull 🔿	radiating	\bigcirc	n/a 🤇	\supset	
What time of day is y					· · · · · · · · · · · · · · · · · · ·			,	_
morning a Do you wake up at ni	afternoon C		evening 🤇	yes 🔿	night time 🔵 no 🔵	č	all day 🔵	n/a	
What makes your pai	-	•							
, ,	medicatio			cise 🔵	sitting 🔵		rest 🔵	elevatior	1 (
	walkin		stand	•			heat 🔵	n/a	
р	hysical therap			age 🔵	athar				
What makes your pai		e 🔵 (Mark all '		oing 🔵	O other				_
	oyment / wor			ing 🔵	squatting 🔵	be	ending 🔵	kneeling	g 🤇
sitting for long	periods of tim	e 🔿		ving 🔵	1 0		0	n/a	
standing for long p	periods of tim weathe			ing 🔵 ving 🔵	Other				
			F						-
INJURY CONDITIC	N								
Date of onset:									_
How did it happen?_									-
)	home		ork (nublic 🔿	auta 🦳	cohe al		_
VA/In a way of the table of	ſ	home 🤇			public 🔘	auto 🔿	school 🤇	> othe	r C
Where did it happen Are you claiming this	as work relat	ed?		yes 🔵	no 🔵				

Print in Color or Grayscale Only Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question.

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PREVIOUS TREATMEN	П					
		or this inium. /	andition)		\frown	
lave you been seen by an f yes, which type of docto	-	or this injury / co	phaltion? ye	es on no	\bigcirc	
ortho	•	MD 🔵	occ med 🔵	chiropractor	other	\sim
/hen did you see the oth				chilopractor		\bigcirc
in last month \bigcirc	•	nths \bigcirc	3-6 months 🔵	6-12 months	over 1 year	. —
ave you had any of the fe				0 12 11011113		
x-rays 🔵	CT 🔵	MRI O	bone scan	other	NONE	\bigcirc
ave you received any of	<u> </u>	<u> </u>				<u> </u>
	injection 🔵	•		no 🔘		
me	edications 🔘	If yes, did it he	elp? yes 🔵	no 🔵		
physica	al therapy 🔵	If yes, did it he	elp? yes 🔵	no 🔵		
	surgery 🔵	If yes, did it he	elp? yes 🔵	no 🔵		
ave you had any previou	s difficulty or inj	jury to this area?	yes 🔵	o no 🔿		
yes, please describe:						
OCIAL HISTORY						
hat is your occupation?						
hat is your marital statu						
single		ried 🔵	divorced 🔵	separated	widowed	\bigcirc
/ho are you living with?						
spouse / partner 🔘	-	ents 🔘	siblings 🤇)	nursing home	\bigcirc
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BAI

Print in Color or Grayscale Only	Patient	History			
Using Adobe Acrobat Reader 8.0 or later	Please answer e	every quest	ion.		
					1
MEDICAL HISTORY (continued)					
Please indicate if you have had any of the	e following cancers.	(If none. m	ark "NONE.")		
brain 🔵		liver 🔿	,	stomach	\circ
breast 🔵	ov	arian 🔵		other cancer	\bigcirc
colon / rectal 🔵	pro	state 🔵			1
lung 🔵	DDADENTS have had	skin 🔿	fellowing (If some me	NONE ")	
Please indicate if your PARENTS or GRAN anesthesia problems	DPAREN IS have had	arthritis		Irk NONE.)	
bleeding disease	he	art disease			
SURGERIES					I
lease indicate if you have had any of the I have had NO SURGE		d no surger	ies please skip ahead to	next section)	
	art valve replacement	-	sinus 🔵		
appendectomy	carotid artery		neck disc 🔾	vasectomy	
hemorrhoidectomy	hernia		lower back disc 🔵	other surgery 🔘	i
heart bypass 🔵	thyroid	\bigcirc	tubal ligation 🔵		I
					I
cesarean section	1	<u> </u>		3 or more 🔵	
gallbladder colon removal	open partial		laparoscopic total		
kidney removal	-	$\overline{\mathbf{O}}$	right O	both 🔵	
D&C	single	~	multiple 🔵		
foot	-	$\overline{\bigcirc}$	right 🔵	both 🔵	I
cataract	left	\bigcirc	right 🔵	both 🔵	
breast cancer lump removal		\bigcirc	right 🔵	both 🔵	
mastectomy		\bigcirc	right 🔵	both 🔵	
breast reconstruction		0	right O	both O	
breast biopsy other breast surgery		\bigcirc	right 🔵 right 🔵	both O	
hysterectomy	partial		total	both	
ovary removal	left		right 🔵	both 🔵	
leg circulation	single	\bigcirc	multiple 🔵		1
prostate surgery	TURP		removal 🔵		
lung		\bigcirc	right 🔵		
carpal tunnel		\bigcirc	right 🔵	both 🔘	
rotator cuff repair arthroscopic shoulder		\bigcirc	right 🔵 right 🔵	both O	
hip fracture & surgery		\bigcirc	right 🔵	both O	
total hip replacement		$\overline{\mathbf{O}}$	right 🔵	both O	
total knee replacement		\bigcirc	right 🔵	both 🔵	
arthroscopic knee		\bigcirc	right 🔵	both 🔵	
spinal fusion	neck		lower back		
spinal decompression ulnar nerve	neck		lower back	hath	
hand		\bigcirc	right 🔵 right 🔵	both O	
other	O		ingint 🕖	both 🔾	
					·
		e 11		<i>"</i>	I
ease indicate if you CURRENTLY are exp	eriencing any of the	tollowing.	(If none, mark "NONE.	·	
ENERAL sweats	f	evers 🔵		appetite loss fatigue (always tired)	
chills		t loss		natigue (always tired)	
'ES eye irritation	vision loss –			discharge	
blurring	vision loss – both			NONE	
(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,328)	Page	-	Copyright © F	atientLink Card 386 (Rev. 10/16/2012)	

Patient History

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Please answer every question. **REVIEW OF SYSTEMS (continued)**

EARS / NOSE / THROAT		
decreased hearing 🦳	difficulty swallowing 🦳	
CARDIOVASCULAR		
chest pain or discomfort 🔵	weight gain 🔵	difficulty breathing while lying down 🔵
swelling of hands or feet 🦳	blackouts / fainting 🔵	shortness of breath with exertions $igodot$
palpitations 🔵	racing / skipping heartbeats 🔵	
RESPIRATORY		
shortness of breath 🦳	wheezing 🔵	coughing up blood 🦳
cough 🔵	chest discomfort 🔵	
GASTROINTESTINAL	diarrhea 🔵	nausea 🔵
vomiting 🔵	loss of appetite 🦳	
GENITOURINARY		
urinary retention 🔵	frequent UTI 🔵	pain 🔵
urinary urgency 🔵	urinary frequency 🔵	
MUSCULOSKELETAL		
	joint pain 🔵	muscle cramps 🔵
joint swelling 🔵	back pain 🔵	muscle weakness 🔵
stiffness 🔵	arthritis 🔵	loss of strength 🦳
gout 🔵	muscle aches 🔵	
SKIN	psoriasis 🔵	changes in nail beds 🔵
suspicious lesions 🔵	dryness 🔵	unusual hair distribution 🔵
poor wound healing 🦳	changes in color of skin 🔘	
NEUROLOGIC		disturbances in coordination 🦳
headaches 🔵	numbness 🔵	falling down 🔵
weakness 🔵	tingling 🔵	visual disturbances 🔵
fainting 🔵	seizures 🔵	memory loss 🔵
poor balance 🔵	tremors 🔵	
PSYCHIATRIC anxiety	depression 🔵	
HEME / LYMPHATIC	abnormal bruising 🔵	
ALLERGIC / IMMUNOLOGIC		
seasonal allergies 🔵	persistent infections 🦳	

ALLERGIES AND MEDICATIONS

Mark here if you have no known	medical aller	gies: 🔵			
Are you allergic to any of the follo latex PCN betadine sulfa metal(s)	owing? (Ple	-			
Other					
Please list all medications you are	e currently ta	king. Include pr	escriptions, over-the-counter n	nedications and vita	amins.
Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency
(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,	328)	Page	4 of 4 Copyri	ght © PatientLink Card 386 (Re	ev. 10/16/2012)