Reason for Visit

Name: _____ Date: _____ Age: _____ Sex: ☐ M ☐ F

Reason for consulting this office (CHECK ALL THAT APPLY):

☐ Pain ☐ Sports Injury ☐ Work ☐ Auto ☐ Home Accident ☐ For optimal health and performance

Describe what brought you to the clinic: _____

Changes in Health History since last visit: _____

Date of onset:_____Have you had ☐X-rays ☐MRIs ☐CTs taken of the area mentioned above? ☐ **Y** ☐ **N**

Describe the pain (CHECK ALL THAT APPLY):

☐ **Deep** ☐ **Superficial** ☐ **Dull** ☐ **Sharp** ☐ **Achy**

☐ **Throbbing** ☐ **Stabbing** ☐ **Shooting** ☐ **Burning** ☐ **Piercing**

What % the day do you have pain? ☐ 0-25% ☐ 25-50% ☐ 51-75% ☐ 76-100%

Have you had this problem in the past**?** ☐ **Y** ☐ **N** If yes, is it the ☐ Same, ☐ Worse, or ☐ Better than before?

Does it affect your regular activities? ☐ **Y** ☐ **N** If yes, how so? _____

When do you feel the best? ☐ Morning ☐ Afternoon ☐ Evening

When do you feel the worst? ☐ Morning ☐ Afternoon ☐ Evening

Severity of pain on a scale of **0 – 10 (0= none, 10= worst imagined): Today? _____At time of injury?_____**

Have you seen anyone else for this condition? ☐ **Y** ☐ **N** If yes, who?_____

What was the diagnosis? _____

How have you treated yourself for this condition? ☐ Ice ☐ Heat ☐ Stretching ☐ Medication

☐ Massage ☐ Exercises ☐ Other_____

Please list anything that makes the condition better: _____

Please list anything that makes the condition worse: _____

Are you currently taking any medications, pain relievers, or supplements? Please list the dosage and reason for taking for all prescriptions and over-the-counter medicines: _____

Do you have allergies? ☐ Y ☐ N If yes, to what and how do you manage an allergy "attack"?

_____

I have completed this form to the best of my ability and discussed the information with Dr. Porman. I understand that Dr. Porman is relying upon this information to make treatment recommendations.

PATIENT SIGNATURE: _____ DATE:_____

If the patient is not yet 18 years old, a parent or guardian must sign.