EMORY PATIENT INFORMATION SHEET

BACKGROUND

Name:_____ Date:_____

Email Address: _____ Phone: _____

Age:_____ Height:_____ Weight:_____ ☐ right handed ☐ left handed

- Occupation:_____
- Sports/Exercise activities:_____
- How did you hear about this treatment at Emory (circle)?
  - Internet
  - Friend
  - Former patient (provide name)_____
  - Physician (provide name)_____
  - Other:_____

LIST ALL CURRENT MEDICATIONS (including over the counter medications)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

REASON FOR VISIT (give a brief history of what body part is bothering you, when it bothers you, and if there was an injury):_____

_____

_____

_____

_____

- How long have you had this problem?_____

MARK PREVIOUS TREATMENTS FOR THIS ISSUE

☐medication- name(s):_____

- Any relief? Y/N If yes, how long?_____

☐physical therapy

- Any relief? Y/N If yes, how long?_____

☐cortisone injection- date(s):_____

- Any relief? Y/N If yes, how long?_____

☐visco injection- (i.e., Supartz, Euflexxa, Synvisc, etc.)- date(s):_____

- Any relief? Y/N If yes, how long?_____

☐surgery- date and type of surgery:_____

- Any relief? Y/N If yes, how long?_____

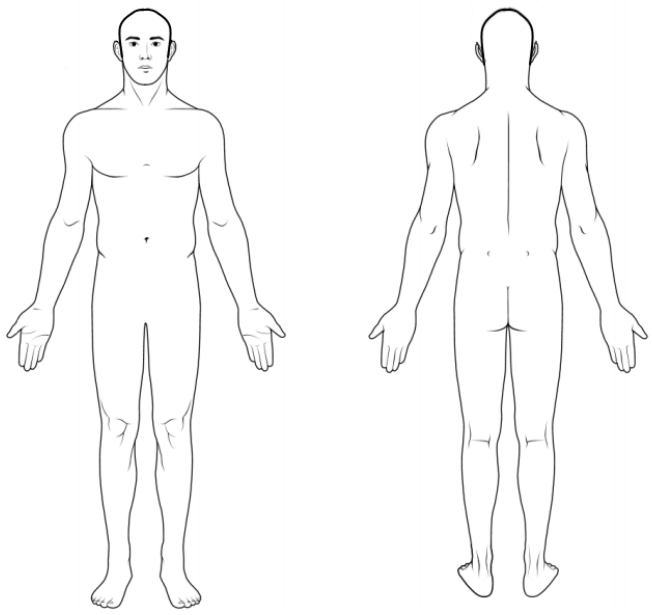
☐other:_____

- Any relief? Y/N If yes, how long?_____

LOCATION OF PAIN (please circle and write the specific area of pain you are interested in treating. Example: outside of left knee, diffuse right shoulder pain, deep inside both hips, etc.)_____

_____

_____



_____

MEDICAL HISTORY (Please choose all current and past medical conditions)

☐ No medical problems	☐ Emphysema	☐ Kidney failure	☐ Blood clots
☐ High blood pressure	☐ Hepatitis	☐ Endometriosis	☐ HIV
☐ Heart attack	☐ Liver disease	☐ Ovarian cysts	☐ Alcoholism
☐ Heart failure	☐ Thyroid disease	☐ Kidney stones	☐ Anxiety
☐ Abnormal heart rhythm	☐ Diabetes	☐ Osteoporosis	☐ Depression
☐ Lung disease	☐ Irritable bowel	☐ Osteoarthritis	☐ Schizophrenia
☐ Tuberculosis	☐ Stomach ulcers	☐ Rheumatoid arthritis	☐Anorexia/bulimia
☐ Asthma	☐ Stroke	☐ Bleeding disorders	☐ Bronchitis
☐ Seizures	☐ Anemia	☐ Cancer/Type _____	

☐ Other: _____

Are you under a doctor's care for any other medical condition? ☐Yes ☐No

If yes, please explain: _____

_____

LIST ANY PAST SURGERIES AND DATES PERFORMED

_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY (Please indicate conditions that run in your close family)

Condition	Family Member (be specific. Maternal g'mother, paternal g'father, etc.)
☐ Arthritis	_____
☐ Heart disease	_____
☐ High blood pressure	_____
☐ Diabetes	_____
☐ Bleeding disorder	_____
☐ Cancer	_____
What type?	_____
☐ Gout	_____
☐ Mental illness	_____
☐ Alcoholism	_____
☐ Kidney disease	_____
☐ Other:	_____

SOCIAL HISTORY

- Do you smoke? □ Yes □ No □ Former – Year Quit_____
  - If yes, how many packs per day? _____
- Do you drink alcohol? □ Yes □ No
  - If yes, how many drinks per week? _____
  - If yes, what type of alcohol? (please circle) Beer Liquor Wine
- Use other drugs? □ Yes □ No
- Marital status: □ Married □ Single □ Divorced □ Widowed

REVIEW OF SYSTEMS (Have you experienced any of the following *recently*)

General

□ Unexplained weight loss
□ Appetite change
□ Fevers or chills
□ Night sweats
□ Marked fatigue
□ Difficulty sleeping

Ear, Eyes, Nose, Throat

□ Difficulty swallowing
□ Hoarseness
□ Loss of hearing
□ Ear pain
□ Nosebleeds
□ Gum trouble
□ Change of vision

Cardiovascular

□ Heart or chest pain
□ Abnormal heartbeat
□ Poor heart function

Digestive

□ Nausea or vomiting
□ Stomach pain or ulcers
□ Heartburn/acid
□ Frequent diarrhea
□ Frequent constipation
□ Uncontrolled loss of stool
□ Blood in stool

Skin

□ Rashes
□ Easy bruising
□ Rashes
□ Frequent itchiness

Neurological

□ Seizures
□ Blackouts/fainting
□ Tremors
□ Headaches/migraines

Psychiatric

□ Depression
□ Nervous exhaustion
□ Anxiety
□ Paranoia
□ Obsessive/compulsive

Genitourinary

□ Blood in urine
□ Incontinence
□ Pelvic pain
□ Burning on urination

Lung

□ Cough
□ Shortness of breath
□ Productive cough