TANNER CLINIC
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NEW PATIENT INFORMATION

NAME: _____ AGE: _____ DATE: _____

DATE OF BIRTH: _____ HT: _____

WHO REFERRED YOU? _____ WT: _____

BP: _____

P: _____

Are you: ☐ Male ☐ Female
☐ Right handed ☐ Left handed ☐ Ambidextrous

CHIEF COMPLAINT:

Reason for visit: _____

Location of your pain:
☐ Head ☐ Shoulder ☐ Mid Back ☐ Leg ☐ Neck ☐ Headaches ☐ Low Back ☐ Arm

HISTORY OF PRESENT ILLNESS:

Date of symptom onset: _____

Type of injury: ☐ Sports Injury ☐ Job Accident
☐ Car Accident (Were you the ☐ Driver or ☐ Passenger? Seatbelted? ☐ No ☐ Yes)
☐ Other (explain): _____

Please describe how you hurt yourself/How your symptoms began: _____

_____

_____

_____

_____

Please describe your current symptoms: _____

_____

_____

_____

_____

On a scale of 0 – 10 mark the number that corresponds to the **severity** of your pain.
("0" means no pain and "10" is the worst pain you can imagine.)

At its worst: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10
At its best: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Which of the following best describes the **character** of your pain?

Timing:
- ☐ Continuous, steady, constant
- ☐ Rhythmic, periodic, intermittent
- ☐ Brief, momentary, transient (Frequency: _____ Duration: _____)

Quality:
- ☐ Throbbing ☐ Burning ☐ Superficial
- ☐ Aching ☐ Tingling/numbness ☐ Deep
- ☐ Sharp ☐ Dull

What makes your pain **worse**? _____

What makes your pain **better**? _____

How long/far can you: Sit _____ Stand _____ Walk _____

Since the onset of your symptoms, is your pain: ☐ Better ☐ Same ☐ Worse

If your pain is changed, by what percentage? ○ 10 ○ 20 ○ 30 ○ 40 ○ 50 ○ 60 ○ 70 ○ 80 ○ 90 ○ 100%

Have you had any loss of bowel or bladder control? ☐No ☐ Yes

PREVIOUS TREATMENT

Have you had treatment since your injury? ☐ No ☐ Yes Have you been to the ER for this? ☐ No ☐ Yes

Have you had any of the following tests or procedures performed?

- X-rays ☐ No ☐ Yes
- MRI ☐ No ☐ Yes
- Epidurals/Injections ☐ No ☐ Yes
- CT Scan ☐ No ☐ Yes
- EMG ☐ No ☐ Yes
- Surgeries ☐ No ☐ Yes

Other (please explain) _____

MEDICAL

Dr. _____ Date of 1st visit _____ Last visit _____
Diagnosis given _____
Medications given _____
Treatment provided _____

CHIROPRACTIC ☐ No ☐ Yes
Dr. _____ Date of 1st visit _____ Last visit _____
Diagnosis given _____
Frequency: ☐ Daily ☐ Three times/week ☐ Two times/week ☐ Weekly

Has it helped? ☐ No ☐ Yes

PHYSICAL THERAPY ☐ No ☐ Yes
Therapist _____ Date of 1st visit _____ Last visit _____

Has it helped? ☐ No ☐ Yes Home exercise program given? ☐ No ☐ Yes

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CURRENT MEDICATIONS:

NAME	DOSAGE	HOW OFTEN DO YOU TAKE?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION ALLERGIES ☐ No ☐ Yes

If yes, please list: Name: Reaction:

_____ _____

_____ _____

_____ _____

_____ _____

ARE YOU ALLERGIC TO or had any reaction to iodine, shellfish, IVP dye, or contrast media? ☐ No ☐ Yes

PAST MEDICAL HISTORY

☐ Anxiety	☐ Heart Attack	☐ Polio	☐ Thyroid trouble	☐ Depression
☐ Asthma	☐ Heart Murmur	☐ Stroke	☐ High Cholesterol	☐ Alcoholism
☐ Cancer	☐ Lung Disease	☐ Parkinson's	☐ Rheumatic Fever	☐ Hepatitis
☐ Diabetes	☐ Ulcers/PUD	☐ Arthritis	☐ Claustrophobia	☐ High Blood Pressure

☐ Other conditions _____

Have you ever had similar symptoms/injury before? ☐ No ☐ Yes

If yes, when: _____ Please describe briefly: _____

_____

PAST SURGICAL HISTORY

Have you had any surgeries? ☐ No ☐ Yes

If yes, please list type of surgery and approximate date:

1. _____ 2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____ 8. _____

FAMILY HISTORY

Please check box for any medical condition that a blood relative has a history of:

☐ Anxiety	☐ Heart Attack	☐ Polio	☐ Thyroid trouble	☐ Depression
☐ Asthma	☐ Heart Murmur	☐ Stroke	☐ High Cholesterol	☐ Alcoholism
☐ Cancer	☐ Lung Disease	☐ Parkinson's	☐ Rheumatic Fever	☐ Hepatitis
☐ Diabetes	☐ Ulcers/PUD	☐ Arthritis	☐ Claustrophobia	☐ Back Problems

☐ Other _____

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SOCIAL HISTORY

Marital Status: (Check one or more)

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ "Living together" ☐ Separated

Number of Children: _____ Ages: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Do you smoke? ☐ No ☐ Yes How much? _____

Previous smoker? ☐ No ☐ Yes When stopped? _____

Do you drink alcohol? ☐ No ☐ Yes How much? _____

Coffee, tea, cola beverages (cups/glasses/cans per day) _____

Do you use recreational drugs? ☐ No ☐ Yes What type/how often? _____

Are you currently employed? ☐ No ☐ Yes If yes, type of job _____

REVIEW OF SYSTEMS: Please mark those items which you <u>currently</u> experience:

GENERAL

☐ Fever ☐ Weight gain ☐ Weight loss ☐ Fatigue ☐ Chills

☐ Weakness ☐ Night sweats

DERMATOLOGY

☐ Jaundice ☐ Itching/rash ☐ Lesions ☐ Easy bruising

HEAD/HEARING & VISION

☐ Trauma ☐ Headaches ☐ Tenderness ☐ Dizziness

☐ Ringing in ears ☐ Blindness ☐ Blurred vision ☐ Changes or hearing loss

☐ Discharge ☐ Rings around lights ☐ Double vision ☐ Light sensitivity

☐ Glasses

PULMONARY

☐ Wheezing ☐ Shortness of breath ☐ Chronic cough ☐ Coughing up blood

CARDIOVASCULAR

☐ Chest pain ☐ Leg swelling ☐ Shortness of breath with exertion ☐ Racing heart

GASTROINTESTINAL

☐ Nausea ☐ Abdominal pain ☐ Bloody stool ☐ Constipation ☐ Diarrhea

GENITOURINARY

☐ Blood in urine ☐ Vaginal discharge ☐ Pregnancy ☐ Pain/burning on urination

☐ Incontinence ☐ Venereal disease ☐ Sexual problems

☐ Painful menstruation ☐ Menopause ☐ Urgency/frequency with urination

☐ Irregular menstruation

MUSCULOSKELETAL

☐ Arthritis ☐ Joint swelling ☐ Trauma

NEUROLOGICAL

☐ Loss of sensation ☐ Seizures ☐ Numbness and tingling

PSYCHOLOGICAL

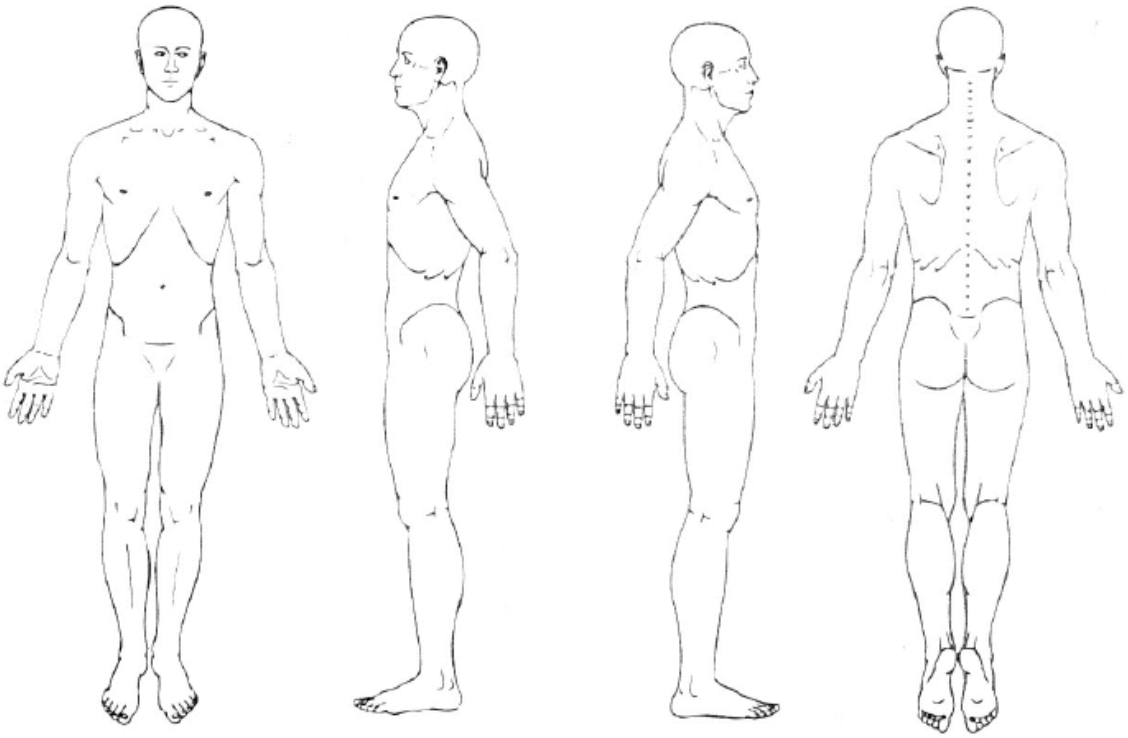
☐ Sadness ☐ Anxiety ☐ Depression

Mark on the pictures below, the areas of your body where you feel the described sensation. Use the symbols listed. Mark the areas of radiating pain or numbness as well. Include all affected areas.

Symbols:

Numbness	Tingling	Burning	Stabbing/Sharp	Aching	Cramping
o o o	: : :	x x x	/ / /	^ ^ ^	□ □ □

Front Left Right Back



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