

Please complete this page in its entirety

Date: _____
Age: _____
Date of birth: _____

Patient's Full Legal Name

Last First MI

Hand dominance:
Right or Left

Occupation: _____

Part of body involved: _____

Rt or Lt

Please explain your symptoms: _____

Date of injury or onset: _____

Was your problem caused by an injury? Yes No

If yes, how did the injury occur? _____

Where did the injury occur? _____

Is this a work related injury? Yes No

Have you ever been seen for this problem before? Yes No

If yes, physician's name : _____

Any type of treatment or testing performed? _____

If testing was done please list date & facility: _____

HEALTH & MEDICATION HISTORY

Do you have any allergies to medication? Yes No

If yes, Please list: _____

Are you presently on medication? Yes No

If yes, Please list _____

List past injuries: _____

List previous surgeries & date: _____

FAMILY PHYSICIAN'S NAME & ADDRESS: _____

How did you here about our office?

Family Physician Ref. _____

Friend Referred - name _____

Other _____

Have you visited our website? yes / no www.drpaley.com