

HISTORY OF PRESENT ILLNESS OR INJURY

NAME _____ **DATE** _____

State the reason for your visit today. _____

What kind of pain do you have? (sharp, burning, aching, etc.) _____

What makes your condition worse?(sitting, standing, running, reaching, etc.) _____
_____.

Is this a work-related problem? NO ___ YES ___

Did you have an injury or accident? NO ___ YES ___ If yes, DATE _____
If so, please describe how it happened. _____
_____.

Have you ever had this same problem before? NO ___ YES ___ WHEN? _____

Have you ever seen another doctor for this problem? NO ___ YES ___
If YES, what treatment was done?(medicines, tests, casts, braces, shots, etc.) _____.
_____.

Have you had physical therapy for this condition? NO ___ YES ___ WHEN? _____.

For this condition only, list recent X-rays, MRI scans, CT scans. _____

WHEN? _____ WHERE? _____

IF YOU HAVE ALREADY BEEN A PATIENT OF DR. NICHOLS BEFORE TODAY:

AGE _____ **HEIGHT** _____ **WEIGHT** _____

Since your last visit, have you had any serious illness, surgery, or injury?

NO ___ YES ___ If yes, please explain. _____

What are your current medications? _____

Do you have any drug allergies? NO ___ YES ___ If yes, please list. _____