NEW PATIENT INFORMATION SHEET

Dr. Todd Kim

Today's Date:

Patient Name:

GENERAL INFORMATION

Who referred you to this office?

Who is your Primary Care Medical Doctor?

Age: Height: Weight: ☐ Right Handed ☐ Left Handed

Current Occupation:

Do you Exercise Regularly? ☐ No ☐ Yes Type of Exercise:

Frequency of Exercise: minutes x per week

What sports or hobbies do you participate in?

HEALTH EVALUATION

Reason for visit today? ☐ Right ☐ Left

☐ Foot ☐ Ankle ☐ Knee/Leg ☐ Hip/Tigh ☐ Shoulder/Arm

☐ Elbow/Forearm ☐ Wrist/Hand ☐ Back

What brings you to the office today?

When or how long ago did this start?

Was there an accident or an activity that started this?

What are your current symptoms? (pain, stiffness, popping, numbness, weakness, giving way, etc)

What makes the condition worse?

What makes the condition better?

I have tried the following treatments:

☐ Orthotics ☐ Cast/Brace ☐ Medication ☐ Physical Therapy ☐ Injections ☐ Surgery

Please rate your pain on a Scale of 0 (no pain) to 10 (worst pain imaginable):

Do you have radiating pain? ☐ No ☐ Yes Where?

Do you have pain at night that wakes you from sleep? ☐ Yes ☐ No

How far can you walk? ☐ Unlimited or (eg. 2 blocks, 1 mile ...)

CURRENT AND PAST MEDICAL CONDITIONS

Please list any current or past medical conditions (e.g. high blood pressure or cholesterol, diabetes, heart condition, asthma, kidney problems, etc)

Please list your past surgeries (include year):

1			4		
2			5		
3			6		

Current Medications (include dosage & frequency):

1		4	
2		5	
3		6	

Do you have any family history (in siblings or parents) of specific medical problems or illnesses? (e.g. heart attack, stroke, cancer, diabetes, other)

☐ No ☐ Yes

PERSONAL

Who lives at home with you?

◯ Live alone ◯ Spouse ◯ Partner ◯ Parents ◯ Children ◯ Siblings ◯ Pets

You are? ◯ Single ◯ Maried ◯ Partnered ◯ Widowed ◯ Separated ◯ Divorced

Do you have any children? ◯ No ◯ Yes (*How many?*)

HABITS

Alcohol: ◯ Never ◯ Occasionally ◯ Daily (drinks per day)

Tobacco: ◯ Never ◯ Quit (years ago) ◯ Daily (packs per day)

ALLERGIES TO MEDICATIONS

Do you have any known allergies? ☐ No ☐ Yes (*please list medications to which you're allergic in the line below*)

Have you or anyone in your family ever had problems with anesthesia?

☐ No ☐ Yes

PAIN DIAGRAM

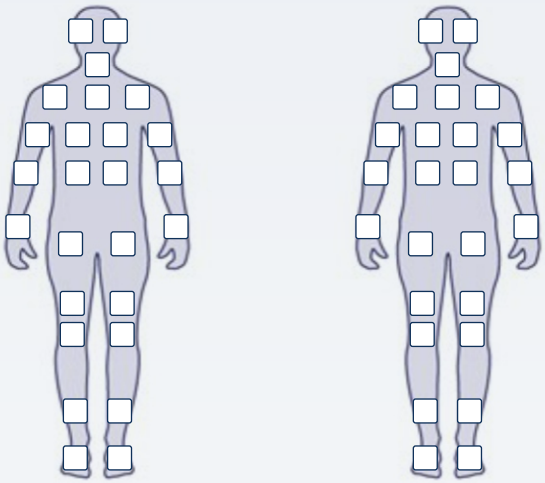
Patient Name: _____ Date: _____

Check the number that describes the severity of your pain:

No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ **Worst Pain**

Mark on the body outline areas where you fee the described sensations. *Use the appropriate symbol:*

Numbness	:	--- --- ---
Burning	:	xxx xxx xxx
Pins & Needles	:	ooo ooo ooo
Pain	:	/// /// ///



REVIEW OF SYSTEM

Please check any that apply:

Constitutional *Physician Comments*
- ☐ Fevers/ Chills/ Sweats
- ☐ Unexplained weight gain/ loss
- ☐ Excessive thirst or urination

Respiratory
- ☐ Cough/ Wheeze
- ☐ Difficulty breathing

Neurologic
- ☐ Headaches
- ☐ Dizziness/ Light Headedness
- ☐ Numbness
- ☐ Loss of Coordination

Skin/ Integument
- ☐ Eczema
- ☐ Rash

Hematologic/ Lymphatic
- ☐ Excessive Bleeding
- ☐ Easy Bruising

Endocrine
- ☐ Diabetes

Cardiovascular *Physician Comments*
- ☐ Chest Pain
- ☐ Palpitations

Gastrointestinal
- ☐ Blood in bowels
- ☐ Abdominal pain
- ☐ Nausea/ Vomiting
- ☐ Diarrhea

Mental Health
- ☐ Anxiety/ Stress
- ☐ Trouble Sleeping
- ☐ Depression

Genitourinary
- ☐ Incontinence
- ☐ Retention
- ☐ Recurrent UTI

Rheumatologic
- ☐ Rheumatoid arthritis

Other/ Not Listed:
- ☐ None Apply/ No Symptoms

Physician Signature: _____ Date: _____

I have reviewed and discussed this with the patient.

PATIENT AGENDA

Communicating with Patients

Date

Patient

Doctor

- What's the most important thing you want to make sure gets accomplished today?

- What other concerns would you like to discuss?

- Please list any precriptions you need refilled today.