NEW PATIENT INFORMATION

1890 AL HWY 157 SUITE
220 CULLMAN, AL 35055
256.737.8055
MUSCLEJOINTMED.COM

Your Name Please

Date of birth

Gender

Social Security Number

Your address

Your email

Cell phone

Primary care Physician Name

Pharmacy

Insurance

MUSCULOSKELETAL HISTORY

Briefly describe your current problem?

When did your current problem start?

Have you been treated for this problem before? ☐ No

☐ Yes

If yes, please provide date of last treatment and name of Physician.

Have you been to rehab for this problem in the last 6 months? ☐ No

☐ Yes

If yes, where did you go to rehab?.

Have you been to the hospital/ER/urgent care or underwent any procedures in the last 6 months? ☐ No

☐ Yes

If yes, please provide dates you went to ER / urgent care or stayed overnight in the hospital or any procedure dates.

Is this problem due to a motor vehicle accident? ☐ No

☐ Yes

If yes, when was the accident?

Are you on disability? ☐ No

☐ Yes

If yes, reason for disability and date disability began.

Is this a workman's compensation claim? ☐ No

☐ Yes

If yes, when was it filed?

SURGICAL/PROCEDURE HISTORY

Do you have a history of any joint / back / neck surgeries? ☐ No

☐ Yes

If yes, please list most recent with dates.

Any other surgeries? ☐ No

☐ Yes

If yes, please list most recent with dates.

Do you have a history of any recent procedures? ☐ No

☐ Yes

If yes, please list most recent with dates.

SPECIALISTS YOU SEE

Do you follow with any other Specialist doctors? ☐ No

☐ Yes

If yes, please list Physician / Specialty and diagnosis?

MEDICAL HISTORY

Do you see a provider for medical problems? ☐ No

☐ Yes

If yes, please list your medical problems.

Do you have a history of cancer or blood problems? ☐ No

☐ Yes

If yes please elaborate?

FAMILY HISTORY

Do you have a family history of rheumatologic problems or crippling arthritis? ☐ No

☐ Yes

If yes, which relative(s).

SOCIAL HISTORY

Have you travelled recently in the last one month? ☐ No

☐ Yes

If yes, where and how did you travel?

Are you married? ☐ No ☐ Yes

Are you currently working? ☐ No

☐ Yes

If yes, where are you employed and what is your position?

Are you retired? ☐ No

☐ Yes

If yes, when did you retire and what kind of activities are you engaged in now?

Do you live alone? ☐ No

☐ Yes

If yes for how long?

Do you have any hobbies or fun activities you engage in regularly? ☐ No

☐ Yes

If yes, please elaborate.

Are you on pain management or receive pain medication from another Physician? ☐ No

☐ Yes

If yes, which clinic or Physician prescribes your medication?

Do you have a history of substance abuse? ☐ No

☐ Yes

If yes, which substance?

Do you drink alcohol? ☐ No

☐ Yes

If yes, how many drinks a week?

Do you smoke? ☐ No

☐ Yes

If yes, whan did you start and how many packs / day?

Do you vape? ☐ Yes ☐ No

Do you dip or chew tobacco? ☐ Yes ☐ No

Do you use any other recreational drugs? ☐ No

☐ Yes

If yes which ones?

MEDICATION HISTORY

Any medication allergies? ☐ No

☐ Yes

If yes please list?

Any recent immunizations/infusions/injections? ☐ No

☐ Yes

If yes what medication and dates?

Are you on blood thinners? ☐ No

☐ Yes

If yes which one and for which diagnosis?

Are you taking any over the counter medication for joint pain? ☐ No

☐ Yes

If yes which ones?

Do you take any supplements? ☐ No

☐ Yes

If yes which ones?

Please list your medications and dosages or attach sheet.

ALTERNATIVE HISTORY

Do you have any other related problem you would like us to know? ☐ No

☐ Yes

If yes, please explain.