NEW PATIENT INFORMATION SHEET

Today's Date: ____________

Name:___________________________________ DOB:_________________ SEX: ☐ M ☐ F

Mailing Address: _________________________ City: ______________ State: _______ Zip: ________

Home Phone: ___________________________ Cell Phone: _____________________________

Email Address: ______________________________________

Primary Language Spoken: ☐ English ☐ Spanish Other: ______________________

- Do you need an interpreter? ☐ Yes ☐ No

Do you have Health Insurance? ☐ Yes ☐ No

- Primary Insurance Name: ______________________________
  - ID #: ___________________________
  - Group Number: ___________________
  - Name of Primary Insured (If other than yourself): ________________________
  - DOB of Primary Insured (If other than yourself): _________________________
- Secondary Insurance Name (if applicable): _______________________
  - ID #: ___________________________
  - Group Number: ___________________
- Primary Care Physician: _______________________________
- How did you hear about us?
  - Internet/Google Search
  - Friend/Former patient: __________________________
  - Physician (provide name) ________________________
  - Physical Therapist ______________________________
  - Chiropractor:__________________________________
  - Other: _______________________________________
- Which procedure do you want to be considered for?
  - Platelet Rich Plasma (PRP)
  - Needle Tenotomy (TENEX)
  - Carpal Tunnel Release (SONEX)
  - Stem Cells (LIPOGEMS or BMAC)
  - Trigger Finger Release

BACKGROUND

Age:________ Ht:___________ Wt:_______________ □ Right-Handed □ Left-Handed

Are you Pregnant? □ Yes □ No

- Occupation: ____________________________________
- Sports/Exercise Activities:____
- Primary Care Physician: ____
- Referring provider (if different than PCP): ____
- Physical therapist: ____
- High school/College or organization (if applicable): ____
- Pharmacy name and town/address: ____

- **REASON FOR VISIT**
- Did you have an injury? □ Yes □ No If yes, what was the date of injury?___________________
- Brief history of what is bothering you, what body part is injured, and how it happened:

____
____
____

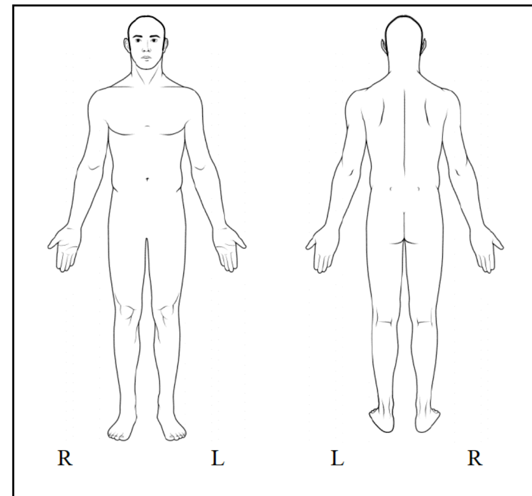
- If this is a work-related injury, is it under workers compensation? □ Yes □ No
  - Have you missed work because of this problem? □ Yes □ No
- If this injury is from an auto accident, is there a legal case? □ Yes □ No

- Please indicate whether you have had any of the following studies and write when/where the most recent was:

	Yes	No	Provide details of imaging study (body part, when/where study performed)
X-ray	□	□	______________________________
CT Scan	□	□	______________________________
EMG	□	□	______________________________
Bone Scan	□	□	______________________________
MRI	□	□	______________________________
Other Imaging Study	□	□	______________________________

LOCATION OF PAIN

- Mark the areas on your body where you feel symptoms. Please include all affected areas



Front Back

HOW SEVERE IS YOUR PAIN?

- On a scale of 0-10 how bad is your pain?

Example: Pain 0 ___ 10

Pain on Average 0 ___ 10

Pain at its Worst 0 ___ 10

Pain at its Best (lying down, resting) 0 ___ 10

0 = no pain 10 = worst pain you can imagine

- Describe your pain (check all that apply)
  - □ Burning □ Numbness □ Tingling □ Decreased sensation □ Dull
  - □ Sharp □ Shooting □ Stabbing □ Throbbing □ Aching
  - Other Symptoms: ______________________________
- When do you have pain?
  - □ Constant □ Intermittent/Occasional □ During/After activities □ At night
- What activities provoke pain? Describe:______________________________
- Does the pain limit your activity? Describe:______________________________
- Have you seen another doctor for this? □ Yes □ No
  - If yes please describe? ______________________________
  - Have you had Surgery for this before? □ Yes □ No

BOSTON SPORTS & BIOLOGICS

If yes please describe?

____

- Have you tried of the following treatments (check all that apply):

  □ Physical therapy

  Location ________________________________

  Dates ________________________________

- Of the following list of treatment, please indicate which you have tried and if they helped:

	Treatment	Which type	Helpful	No help
□	Anti-inflammatory Medications	□ Ibuprofen	□	□
		□ Advil	□	□
		□ Naproxen	□	□
		□ Celebrex	□	□
		□ Other:	□	□
□	Muscle Relaxants		□	□
□	Narcotic Pain medications	□ Tramadol	□	□
		□ Oxycodone/Hydrocodone	□	□
□	Cortisone Injection	□ Date(s):	□	□
	□ Ultrasound Guided?	□ Date(s):	□	□
□	Physical Therapy		□	□
□	Chiropractor	□ Date(s):	□	□
□	Ice		□	□
□	Hot Packs			
□	Trigger Point Injection	□ Date(s):	□	□
□	Acupuncture	□ Date(s):	□	□
□	Shock wave Therapy	□ Date(s):	□	□
□	PRP/Orthobiologic Injection	□ Date(s):	□	□
□	Other:		□	□

GENERAL MEDICAL HISTORY

ALLERGIES

____

____

____

MEDICATIONS (Please list all prescribed and over-the-counter medications, vitamins, and supplements)

____

____

____

PAST MEDICAL HISTORY □ **NO MEDICAL PROBLEMS**

Please choose all current and past medical conditions:

□ Heart attack
□ High blood pressure
□ Heart failure
□ Abnormal heart rhythm
□ Stroke
□ Lung disease A
□ Asthma/Bronchitis
□ Emphysema/COPD
□ Diabetes
□ Thyroid disease
□ Irritable bowel
□ Stomach Ulcers
□ Rheumatoid Arthritis
□ Osteoarthritis
□ Seizures
□ Cancer, Type___________________________
□ Liver disease
□ Kidney failure
□ Bleeding disorders
□ Anemia
□ Blood clots in legs/lungs
□ Osteoporosis
□ HIV/Hepatitis/Tuberculosis
□ Endometriosis
□ Ovarian Cyst
□ Kidney stones
□ Anxiety
□ Depression
Anorexia/bulimia
□ Bipolar/Schizophrenia
□ OTHER: ___________________________________

Are you under a doctor's care for any other medical condition? □Yes □No

If **yes**, please explain:____

PAST SURGERIES (Please list any surgery and ***month/year*** of surgery)

□ DATE:__________ □ PROCEDURE:_______________________________________

□ DATE:__________ □ PROCEDURE:_______________________________________

□ DATE:__________ □ PROCEDURE:_______________________________________

□ DATE:__________ □ PROCEDURE:_______________________________________

□ DATE:__________ □ PROCEDURE:_______________________________________

FAMILY HISTORY (Please indicate conditions that run in your ***close family (mom/dad/sibling/grandparents)***. If yes, please indicate relationship)

Condition	Family Member	Condition	Family Member
□ Heart disease/High blood pressure	____________	□ Gout	____________
□ Diabetes	____________	□ Cancer, Type?	____________
□ Bleeding disorder	____________	□ Other	____________

SOCIAL HISTORY

- Do you smoke? □ Yes □ No □ Former (Quit____________) If yes, how many packs per day? __________
- Do you drink alcohol? □ Yes □ No If yes, how many drinks per week?_________

REVIEW OF SYSTEMS (Have you experienced any of the following *recently*)

General
□ Changes in appetite
□ Fevers □ Fatigue □ Chills
□ Lightheadedness
□ Night sweats
□ Unexplained weight gain
□ Unexplained weight loss

Allergy/Immunology
□ Hives □ itching □ rash
□ Sneezing □ Wheezing

Eyes/Opthalmologic
□ Dry eyes □ Eye pain
□ Flashes of light □ Floaters
□ Loss of vision

Ear, Nose, Throat
□ Difficulty swallowing
□ Dry mouth □ Hoarseness
□ Ringing in Ears
□ Decreased hearing
□ Nosebleeds

Endocrine
□ Weight loss
□ Dizziness

Respiratory
□ Cough
□ Shortness of breath at rest
□ Shortness of breath with exertion
□ Sputum production

Cardiovascular
□ Chest pain Heartburn/acid
□ Shortness of breath
□ Palpations

Gastrointestinal
□ Abdominal pain
□ Blood in stools
□ Weight loss
□ Nausea □ Vomiting
□ Diarrhea
□ Constipation
□ Rectal bleeding

Genitourinary
□ Blood in urine
□ Difficulty urinating
□ Frequent urination
□ Painful urination

Skin
□ Rash □ itching
□ Discoloration

Neurologic
□ Seizures
□ Paralysis
□ Fainting
□ Dizziness

Psychiatric
□ Depressed mood
□ Eating disorder
□ Loss of appetite
□ Mental or physical abuse
□ Suicidal thoughts

Thank you for taking the time to complete this form

Patient's Signature:____ Date: __________