

New Jersey Sports Medicine and Performance Center LLC
689 Valley Road, Suite 104, Gillette, NJ 07933

Today's Date: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Date of Injury or Onset of Symptoms: _____

Briefly Describe Present Symptoms: RIGHT LEFT _____

What makes your pain better? _____

What makes your pain worse? _____

Have you had similar symptoms before? Yes No When? _____

List X-ray, MRI, or studies that have been done (DATE and LOCATION):

List Physicians that have treated you for these symptoms:

Did a health care provider recommend that you see us (NAME and ADDRESS)?

Does this involve: Motor Vehicle Accident Liability Workman's Compensation

Medications/Vitamins/Supplements: NONE

Allergies to any medications, latex, injections etc: NONE

Past Medical History: NONE

Previous Surgeries: NONE

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Social History:

Smoking	Occasional	Moderate	Heavy	None	Quit ____ years ago
Alcohol	Occasional	Moderate	Heavy	None	
Substance Use	Occasional	Moderate	Heavy	None	
Exercise	Occasional	Moderate	Heavy	None	
Sleep	Restful	Non-restful	Poor		
Occupation:	_____				

Family History:

Heart Disease Stroke Cancer Diabetes Arthritis Osteoporosis

Other: _____

Review of Systems (Are you currently experiencing any of the following):

General Health fatigue fever, sweats, chills recent weight change	Brain/Nerves headache dizziness blackouts	Blood/Lymphatic anemia swollen lymph node bleeding/bruising	Bone/Joint/muscle joint swelling joint warmth joint stiffness
Lungs (Respiratory) short of breath cough wheeze	numbness/tingling tremor/shaking weakness memory loss	Endocrine/Metabolic elevated blood sugar excessive thirst excessive urination heat/cold intolerance hair loss/skin changes	muscle pain back pain arm pain leg pain weakness
Heart/Vascular chest pain irregular heart beat leg swelling leg cramping	Vision change in vision visual disturbances	Gastrointestinal diarrhea constipation change in bowel habit abdominal pain abdominal bloating bloody/black stools nausea/vomiting	Other problems: _____ _____ _____
Ear/nose/throat frequent infections allergy/hay fever sinus problems	Skin/Dermatology rash sores/wounds itching		
Psychiatric feeling anxious feeling depressed suicidal counseling	Urinary/genital frequent urination nighttime urination blood in urine painful urination leaking urine discharge		

FEMALES:

Pregnant: Yes No Planning: Yes No

Menstrual Flow: Regular every month Irregular Days of flow _____ Length of cycle _____

Date of last menstrual period _____

Date of last pap _____ Normal Abnormal

Date of last mammogram _____ Normal Abnormal

Do you want to lose weight? Yes No Are you on a diet? Yes No

History of eating disorders? Yes No