the pirATe clinic

New Patient History & Screening Form

Name: ____**Date of Birth (MM/DD/YY)** _____/______/______

Age: _________ **Height: _____ft_____in** **Weight**: _________ **Are you a Whitworth:** ☐Student ☐Employee

Students, are you a varsity athlete at Whitworth University? ☐Yes ☐No

Who referred you? ☐Whitworth Health Center ☐Physician ☐Self (no referral) ☐Other:__________________

Are you physically active: ☐Yes, frequently ☐Yes, occasionally ☐Yes, rarely ☐No, never

How do you identify? ☐Male ☐Female ☐Non-binary ☐Prefer not to say

History of Injury

Is this related to a: ☐Work Injury? ☐Sports/Recreation Injury? **Hand dominance:** ☐Right/ ☐Left

Which body part is injured? ____ ☐Right/ ☐Left

Please list the injury/accident date: ___________________ **If chronic list how long:** _________________

Please describe in your own words how the initial injury occurred:

____

____

____

Please rate your pain using the scale below on a scale of 0 to 10: (0 no pain / 10 being the most painful)

Current: 0 1 2 3 4 5 6 7 8 9 10 **At its worst:** 0 1 2 3 4 5 6 7 8 9 10

At its best: 0 1 2 3 4 5 6 7 8 9 10 **Is the pain:** ☐Constant or ☐Occasional

Has the pain been: ☐Worsening ☐Stable ☐Improving **Do you have pain at night?** ☐Yes/No

Describe the pain: ☐Aching ☐Burn ☐Dull ☐Sharp ☐Throbbing ☐No pain

What is your current activity status?

☐Full activity/Fully duty ☐Modified activity/Light duty ☐Unable to work/be active ☐Unable perform self-care

☐Other (please describe): _________________________

What symptoms are you experiencing?

☐Locking ☐Catching ☐ Giving Way/Instability ☐Popping ☐Grinding ☐Bruising ☐Numbness ☐Tingling

☐Pain ☐Weakness ☐Swelling ☐Other (please describe): _________________________

What, if anything, makes your symptoms better?

☐Rest ☐Activity ☐Cold Therapy ☐Medication ☐Other (please describe): _____________________

What, if anything, makes your symptoms worse?

☐Inactivity ☐Exercise (Describe): ______________________ Other (please describe): ______________

What treatment have you tried for this injury?

☐Nothing ☐Exercise ☐Ice ☐Decreased Activity ☐Bracing ☐Injections (i.e. Synvisc/ Cortisone)

☐Physical Therapy ☐Acupuncture ☐Chiropractic ☐Other: ____________________________________

Have you injured this body part/area before? ☐Yes/ ☐No. If yes, please describe: ___________________________

____

Have you seen a physician for this injury? ☐Yes/ ☐No

Surgical History

Please list all surgeries to the body area you are being seen for today (Please include year of surgery):

____

____

PAST MEDICAL HISTORY

Please check if you currently suffer from:

Asthma	☐Yes/ ☐No		Arthritis	☐Yes/ ☐No
Chronic obstructive pulmonary disease (COPD)	☐Yes/ ☐No		Cancer	☐Yes/ ☐No
Chest pain at rest	☐Yes/ ☐No		Depression	☐Yes/ ☐No
Chest pain with exercise	☐Yes/ ☐No		Diabetes	☐Yes/ ☐No
Deep Vein Thrombosis (Blood Clot)	☐Yes/ ☐No		Gastritis/Ulcer/GERD	☐Yes/ ☐No
Dizziness or loss of balance	☐Yes/ ☐No		Gout	☐Yes/ ☐No
Elevated Cholesterol	☐Yes/ ☐No		History of MRSA	☐Yes/ ☐No
Heart Disease/ Attack	☐Yes/ ☐No		Osteoporosis	☐Yes/ ☐No
High Blood Pressure	☐Yes/ ☐No		Polio	☐Yes/ ☐No
Pulmonary Embolism	☐Yes/ ☐No		Seizures	☐Yes/ ☐No
Shortness of Breath	☐Yes/ ☐No			
Stroke	☐Yes/ ☐No			
Do you have other health conditions we should know about (please briefly list):				

Do you have a pacemaker? ☐Yes/ ☐No

Have you ever had heart, brain or artery surgery? ☐Yes/ ☐No

Allergies

Are you allergic to: Latex? ☐ Yes/ ☐ No

Are there any other allergies we should know about to safely provide care? ☐Yes/ ☐No

____

____

Medications (Please list all prescription medications)

Medication	**What For?**