

Date \_\_\_\_\_ Please list any former last names \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Sex: Male Female Ethnic Origin \_\_\_\_\_

Daytime phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Pager \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone # \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

<p>Allergies</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Height &amp; Weight</p> <p>_____</p> <p>_____</p> <p>_____</p>
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**MEDICATIONS OF PATIENT**

Please list all medications you are taking including prescription, nonprescription, herbal and vitamins.

Medication	Reason taken	Dose & #/Day	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I am currently not taking any medication \_\_\_\_\_ (Initial)

**GENERAL MEDICAL HISTORY OF PATIENT**

Do you have or have you ever had any of the following conditions? (Please circle)

- |                                     |                           |                                     |
|-------------------------------------|---------------------------|-------------------------------------|
| Degenerative arthritis              | Heart attack / Angina     | Psoriasis                           |
| Rheumatoid arthritis                | Heart failure             | Lupus/immune disorder               |
| Asthma                              | Hepatitis - liver failure | Previous oral steroids (prednisone) |
| Blood clot in leg - phlebitis       | High blood pressure       | Previous fractures                  |
| Blood clot in lung                  | Kidney disease / stones   | Claustrophobia                      |
| Diabetes - Type 1 ____, Type 2 ____ | Lung Problems             | ADHD - Attention deficit disorder   |
| Epilepsy/Seizures                   | Stroke / TIA's            | Depression / Anxiety                |
| Emphysema/COPD                      | High cholesterol          | Other psychiatric problems          |
| Fibromyalgia                        | Thyroid Problems          | Intestinal problems                 |
| Gastric Reflux/Stomach ulcer        | Osteoporosis              | Gout                                |
| Colitis                             | Drug / Alcohol Dependence | Enlarged prostate                   |
| Anemia                              | Bleeding tendency         | Cancer - Type _____                 |

Patient's initials \_\_\_\_\_ Date \_\_\_\_\_

**Please list any surgery you have had in the last 5 years.**

Type of Surgery	Date
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

**SOCIAL HISTORY OF PATIENT**

**Marital Status (circle one answer)**    Married    Single    Separated    Divorced    Widow/Widower

**Smoking**

Do you, or have you ever, smoked?    No    Yes                      If yes, please complete the following  
 I smoke \_\_\_\_\_ per day and I have smoked for \_\_\_\_\_ years.  
 I did smoke \_\_\_\_\_ per day, but I quit smoking \_\_\_\_\_ years ago.  
 Do you use any smokeless tobacco products?    No    Yes

**Alcohol**

Do you drink?    No    Yes                      If yes, how much?    Rarely    Socially    Daily

**Education (circle the highest level of education you completed)**

Grammar School                      High School                      College                      Post-graduate

**FAMILY MEDICAL HISTORY**

I do not know the medical history of my biological parents or other family members (go to next section)

Mother:    My mother is alive and is \_\_\_\_\_ years old  
                   She is in good health                      She suffers with \_\_\_\_\_  
                   My mother is deceased at age \_\_\_\_\_ Cause \_\_\_\_\_

Father:    My father is alive and is \_\_\_\_\_ years old  
                   He is in good health                      He suffers with \_\_\_\_\_  
                   My father is deceased at age \_\_\_\_\_ Cause \_\_\_\_\_

I have \_\_\_\_\_ living brothers /sisters.  
 I have \_\_\_\_\_ deceased brothers/sisters. Cause(s) \_\_\_\_\_

Members of my family (biological parents, brothers/sisters, grandparents, aunts/uncles) have been diagnosed with the following (please circle all that apply):

- |                     |                       |                   |
|---------------------|-----------------------|-------------------|
| Stroke              | Back problems         | Arthritis         |
| Diabetes            | Scoliosis or Kyphosis | Bleeding problems |
| Lung disease        | Kidney problems       | None of these     |
| High blood pressure | Cancer                | I don't know      |
| Heart trouble       | Osteoporosis          | other _____       |

Patient's initials \_\_\_\_\_ Date \_\_\_\_\_

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**WORK STATUS**

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What is your usual occupation?

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Before having this pain/injury, did you normally work (circle answer):    Full-time            Part-time

Please indicate your current work status (circle only one answer):

Working full-time

Working part-time

Seeking employment

Not employed by choice (retired, student, etc.)

Physically unable to work due to \_\_\_\_\_

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Has your pain affected your ability to do your job or to get a job?            Yes    No    N/A

Do you like your work situation?            Yes    No    N/A

Are you currently involved in litigation with regards to this injury?            Yes    No

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**REVIEW OF SYSTEMS**

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**Do you at present have any of the following? (Please circle yes or no for each item)**

**General:**

Recent weight loss more than 10 pounds    Yes    No

Recent weight gain more than 10 pounds    Yes    No

Fever            Yes    No

Chills            Yes    No

Night sweats    Yes    No

**Head / Neck:**

Eye problem            Yes    No

Sore throat            Yes    No

Swollen neck glands    Yes    No

**Cardiovascular:**

Chest pain            Yes    No

Irregular heartbeat    Yes    No

Leg / feet swelling    Yes    No

Leg / foot ulcer            Yes    No

**Respiratory:**

Wheezing            Yes    No

Pneumonia            Yes    No

Cough            Yes    No

Shortness of breath    Yes    No

**Gastrointestinal:**

Abdominal pain            Yes    No

Nausea / Vomiting            Yes    No

Diarrhea            Yes    No

Black tar-like or bloody stools    Yes    No

**Endocrine:**

Heat or cold intolerance            Yes    No

**Skin:**

Rash            Yes    No

Open sores            Yes    No

New moles            Yes    No

Poor healing            Yes    No

Skin infection            Yes    No

**Hematologic / Oncologic:**

Anemia            Yes    No

Easy bleeding or bruising    Yes    No

Recent blood transfusion    Yes    No

**Bone / Joints:**

Joint swelling            Yes    No

Joint pain            Yes    No

Pain in multiple joints    Yes    No

Weakness            Yes    No

**Genitourinary:**

Bladder infection            Yes    No

Pain with urination            Yes    No

Frequent urination            Yes    No

Difficulty with urination    Yes    No

**Neurological:**

Anxiety / Depression            Yes    No

Headaches            Yes    No

Tremors            Yes    No

Speech problems            Yes    No

Changes in vision            Yes    No

Feeling of hopelessness            Yes    No

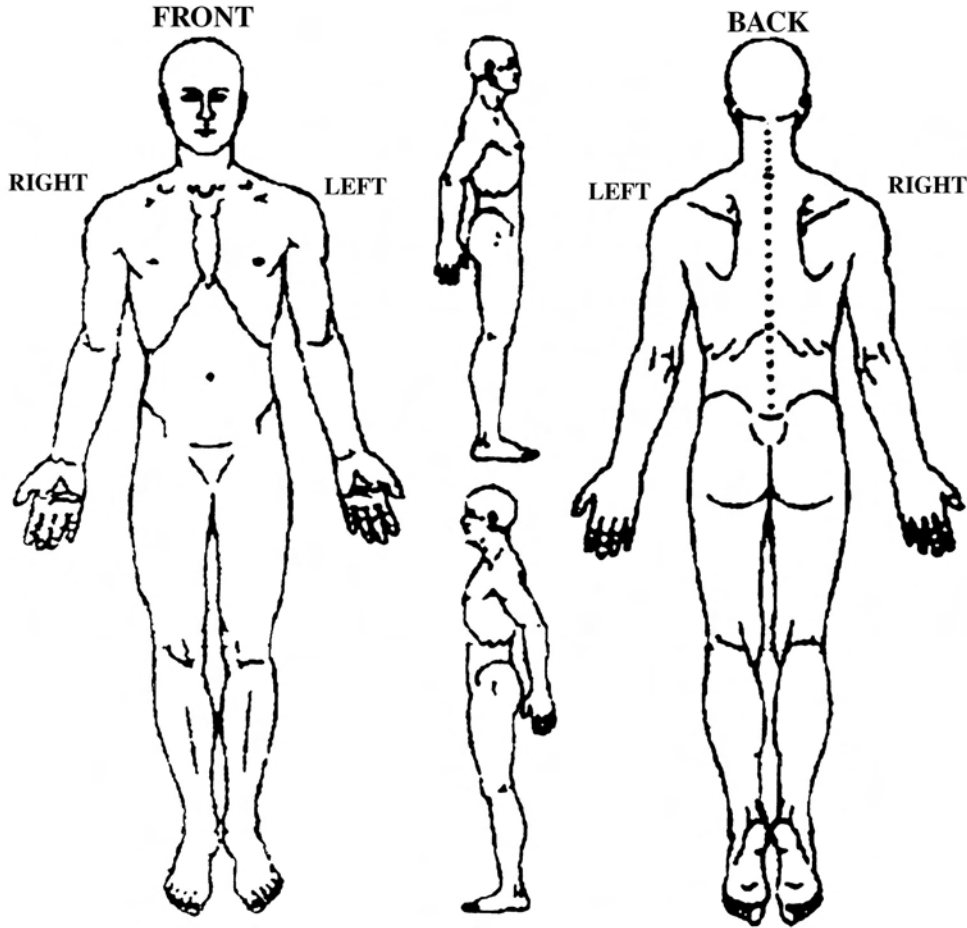
Sleep disturbance            Yes    No

Patient's initials \_\_\_\_\_ Date \_\_\_\_\_

**PAIN DIAGRAM**

Please mark the areas where you experience the following sensations:

	xxx	ooo	---	^^^	///
Ache	xxx	Numbness	ooo	Pins &	---
	xxx		ooo	Needles	---
				Burning	^^^
					^^^
					///
					///



Physician Initials	Date	Physician Initials	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient's initials \_\_\_\_\_ Date \_\_\_\_\_