



Due to government requirements that physicians document complete medical information on each patient, we ask you to complete the following detailed form in its entirety. Should you have trouble with any of the questions, please feel free to ask our staff for assistance. Some of the information may be sensitive; rest assured that the staff will keep this information confidential. Thank you for your cooperation.

1. PATIENT IDENTIFICATION

Name: _____ Date: _____ Updated: _____
 Age: _____ Date of Birth: _____ Who is your primary / family doctor?: _____
 How were you referred to our office: Self ER (which one?): _____
 Referred By (name): _____ Other (list name): _____

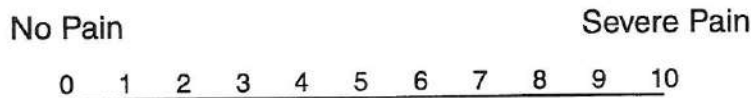
2. PRESENTING COMPLAINT / PROBLEM

Reason for visit: _____ Date of onset: _____
 Cause of injury: _____ Where occurred?: _____
 Work-related?: Yes No Previous injury?: _____
 Previous studies? Where performed & Date?
 X-Rays _____ MRI _____
 CT Scan _____ Bone Scan _____
 Other _____ Nerve Conduction Studies _____
 Right Handed Left Handed

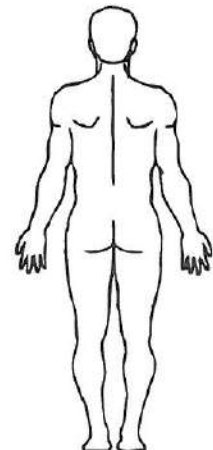
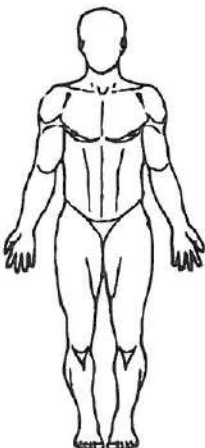
PAIN DRAWING

Be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness = = = = Pins & Needles o o o o Burning Pain x x x x Stabbing Pain / / / / Aching Pain ((((



PAIN SCALE



3. MEDICAL HISTORY

CHECK YES or NO to indicate if you have EVER had any of the following disorders, and **circle** the appropriate condition.

- General:** Rheumatoid Arthritis, Cancer (where) _____ Yes No
- Eyes / Ears:** Glaucoma, Hearing Loss Yes No
- Neuro:** Migraine headaches, Seizures, Epilepsy, Stroke, Polio, Nerve Injury, Meningitis Yes No
- Endocrine:** Diabetes, Thyroid Disorder, Adrenal Insufficiency Yes No
- Cardiac:** Coronary Artery Disease, Angina, Heart Attack, Arrhythmia, Valve Disease, Rheumatic Fever, Stents Yes No
- Respiratory:** Asthma, Emphysema, Tuberculosis, Blood clot to lungs, Bronchitis, Pneumonia Yes No
- GI:** Reflux / Ulcer Disease, Liver Disease / Hepatitis, Bowel Disease Yes No
- GU:** Kidney Disease, Renal Failure, Urinary Problems, Prostate Problems, Infections Yes No
- Vascular:** High blood pressure, Phlebitis, DVT / Clot, Anemia, Bleeding Disorder Yes No
- Psych:** Mental illness, Depression, Bipolar Disorder, Anxiety Yes No
- Other:** Alcoholism, Osteoarthritis, Osteoporosis, AIDS, Social Drugs, _____ Yes No
- Serious Injury:** (where?) _____ Yes No

4. PREVIOUS SURGERIES / HOSPITALIZATIONS – list all past surgeries and dates

Any complications with surgery or anesthesia?:

5. MEDICATIONS – INCLUDE HERBAL SUPPLEMENTS AND OVER THE COUNTER MEDICATIONS

MEDICATION	DOSE # TIMES PER DAY	MEDICATION	DOSE # TIMES PER DAY

6. ALLERGIES (DRUG REACTIONS)

Are you allergic to any drugs or have you had any reactions to medications? Yes No
 If YES, LIST the drugs and the type of reaction:

7. FAMILY HISTORY (biological grandparents, parents, siblings) – is there a family history of any serious medical conditions – such as diabetes, hypertension, heart disease, cancer?

Yes No if YES, please explain: _____

8. SOCIAL HISTORY

Single Married Divorced Widowed Number of children living _____

Presently living alone? Yes No

Stairs at home? Yes No Number of steps _____

Occupation: _____ Still at work? Yes No if no, last date worked: _____

How long at present job? _____

Physical demands of work: Heavy Moderate Light Lifting Pushing
 Squatting Prolonged standing Sitting

Alcohol use: Never Rare Occasional Moderate Heavy Quit how many years ago? _____

Tobacco use: Nonsmoker Smoker #packs per day _____ Years _____

Previous Smoker How many years ago? _____

Drug use: Yes No Past What type? _____

Sports / Exercise prior to injury? Yes No What type? _____

Number of times/week: _____ Recreational School / College level Semi / Professional

How has injury affected these activities? _____

9. REVIEW OF SYSTEMS General Health: Good Average Fair Poor

Circle to indicate if you have had any of the following symptoms pertaining to today's visit only.

Unexplained weight loss, Fatigue, Fever, Chills, Blurred vision

Hearing loss, Ringing in ears, Hoarseness, Sore throat

Chest pain, Palpitations, Irregular heart beat, Murmur, Racing heart, Lower ext. edema

Shortness of breath, Cough, Blood in sputum, Wheezing, Sleep apnea

Abdominal pain, Constipation, Diarrhea, Vomiting blood, Black stool, Nausea, Jaundice

Burning with urination, Urinary frequency, Blood in urine

Bone or joint infections, Swollen joint, Gout, metal implant, fractures or dislocations

Skin color changes, Rashes, Lesions, Nodule, Skin ulcers

Headache, Dizziness, Seizures, Difficulty walking, Tingling

Anxiety, Depression, Nervousness, Insomnia

Bruise easily, Swollen glands, Nosebleeds, Gum bleeding, Blood disorders

Prior blood transfusions? If yes, when _____

Are you claustrophobic? YES or NO

Are you pregnant?

YES or NO

Other symptoms? Please specify _____

Patient Signature _____ Date _____

I have reviewed this form and used the data in forming my opinion and making recommendations

Physician's Signature _____ Date _____

Physician's Signature _____ Date _____