



PATIENT INFORMATION	PHONE NUMBERS
<p>Date: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Name: _____</p> <p>Address: _____ _____</p> <p>City: _____ State: _____ Zip: _____</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced</p> <p>Birth Date: _____ Age: _____</p> <p>Patient SS#: _____</p> <p>How did you hear about us? : _____</p>	<p>Home: _____ Work: _____</p> <p>Cell: _____</p> <p><input type="checkbox"/> AT&T <input type="checkbox"/> Verz <input type="checkbox"/> T-Mob <input type="checkbox"/> Nextel <input type="checkbox"/> Virgin <input type="checkbox"/> Sprint</p> <p>Email: _____</p> <p>Best time to reach you: _____</p> <p>EMERGENCY CONTACT: _____</p> <p>Relationship: _____</p> <p>Phone #: _____</p> <p>Spouse's Name: _____ DOB: _____</p>
EMPLOYMENT	PHYSICIAN INFO.
<p>Occupation: _____</p> <p>Employer: _____</p> <p>Employed: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not Working</p> <p>If you are unemployed, is this due to your present pain condition: <input type="checkbox"/> Yes or <input type="checkbox"/> No</p> <p>If you are unemployed, indicate how long you have been off of work: _____</p>	<p>Referring MD: _____</p> <p>Primary Care MD: _____</p> <p>Physicians currently involved in care: _____ _____ _____</p>
INSURANCE	ACCIDENT INFORMATION
<p>Insured's Name: _____</p> <p>Relationship to Patient: _____</p> <p>Insurance Co.: _____</p> <p>ID #: _____</p> <p>Additional Insurance: _____</p> <p>Subscriber's Name: _____</p> <p>Birth Date: _____ SS#: _____</p> <p>Relationship to Patient: _____</p>	<p>Is this condition due to an accident: <input type="checkbox"/> YES <input type="checkbox"/> NO If known, what was the date of the injury: (___/___/___)</p> <p><input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Personal Injury/ Liability <input type="checkbox"/> Other</p> <p>To whom have you made a report of this accident:</p> <p><input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Other</p> <p>Attorney Name & Phone Number (if applicable): _____ _____</p>

Date: _____ Name: _____ DOB: _____

**What's your single most important complaint / problem for which you are seeking treatment?
Describe how it feels. (Additional complaints can be listed on the next page)**

ONSET: When/How did your complaint start? (check appropriate boxes)

When did it first start? _____ years _____ months _____ week _____ days

Suddenly Gradually Bending Pulling Lifting Fall Injured at work

Injured during sports Injured in auto accident Unknown Other _____

Have you had this complaint before? Yes - describe: _____ No

SEVERITY OF PAIN: Please describe the intensity of your complaint:

Mild Moderate Moderate - Severe Severe

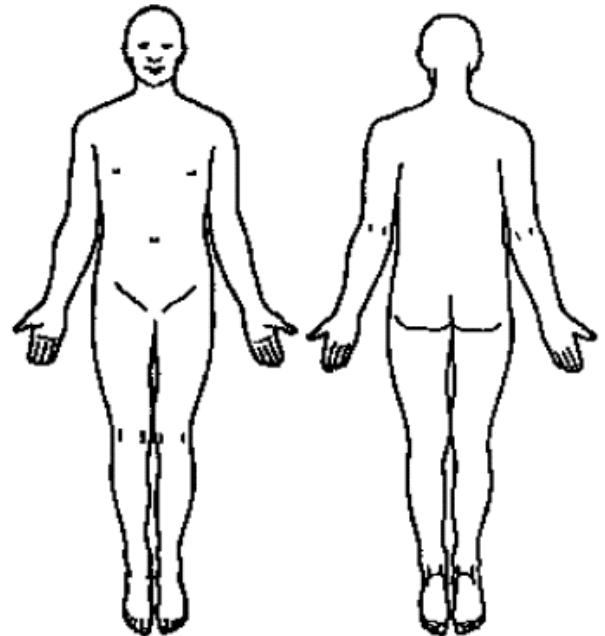
TIMING OF PAIN: How often do you have your complaint? Constant Intermittent Occasional

Is your sleep disturbed by your complaint? Yes - How many times do you wake/night _____ No

Is the complaint getting worse? Yes - describe: _____ No

How are the following affected by your complaint (please check one for each item)?

	Aggravates	Not Affected	Alleviates
Lying Down			
Standing			
Walking			
Sitting			
Sit & Pushup on hands			
Sit with Support			
Bending Slightly			
Bending Fully			
Coughing/Sneezing			
Raising Arm Overhead			
Driving			
Hygiene / Bathing			
House Cleaning			
Work			



PAIN LOCATION: Please mark the location(s) of your **primary** complaint symptoms on the diagrams using: **X=Pain B=Burning C=Cramping N=Numbness S=Soreness ST= Stiffness T=Tingling W=Weakness R=Radiating**

Have you taken any recent falls? ___ Yes ___ No

How many blocks can you walk? # _____ Blocks

To assist walking, I use a: ___ Cane ___ Walker ___ Wheelchair
___ No Assistance Device

Have you unintentionally dropped objects recently: ___ Yes ___ No

MOTIVATION / COMMITMENT:

What lifestyle changes have you had to make due to this complaint? _____

How important is it to you, to do whatever it takes to re-gain these aspects of your life? (1-10) _____

Date: _____ Name: _____ DOB: _____

SECOND COMPLAINT: _____ When & how did this complaint start? _____

What makes the complaint worse? _____

What makes the complaint better? _____

What words would you use to describe this complaint? _____

Does your condition radiate anywhere? _____

What is the severity of your complaint 0-10 (0=best, 10=crippling/bedrest required) _____

What time of the day is your complaint the worst? _____

Before this complaint began, had you ever experienced this type of problem before? _____

What lifestyle changes have you had to make due to this complaint? _____

How important is it to you, to do whatever it takes to re-gain these aspects of your life? (1-10) _____

THIRD COMPLAINT: _____ When & how did this complaint start? _____

What makes the complaint worse? _____

What makes the complaint better? _____

What words would you use to describe this complaint? _____

Does your condition radiate anywhere? _____

What is the severity of your complaint 0-10 (0=best, 10=crippling/bedrest required) _____

What time of the day is your complaint the worst? _____

Before this complaint began, had you ever experienced this type of problem before? _____

What lifestyle changes have you had to make due to this complaint? _____

How important is it to you, to do whatever it takes to re-gain these aspects of your life? (1-10) _____

FOURTH COMPLAINT: _____ When & how did this complaint start? _____

What makes the complaint worse? _____

What makes the complaint better? _____

What words would you use to describe this complaint? _____

Does your condition radiate anywhere? _____

What is the severity of your complaint 0-10 (0=best, 10=crippling/bedrest required) _____

What time of the day is your complaint the worst? _____

Before this complaint began, had you ever experienced this type of problem before? _____

What lifestyle changes have you had to make due to this complaint? _____

How important is it to you, to do whatever it takes to re-gain these aspects of your life? (1-10) _____

Date: _____ Name: _____ DOB: _____

DIAGNOSTIC STUDIES:

Which complaint have you had diagnostic studies for? ___Primary ___Secondary ___Third ___Fourth

X-Rays: Yes (of what) _____ No _____ **CT (Computed Tomography) Scan:** Yes (of what) _____ No _____

Discogram: Yes (of what) _____ No _____ **Electromyogram (EMG) / NCV:** Yes (of what) _____ No _____

MRI: Yes (of what) _____ No _____ **DEXA (Bone Density Testing):** Yes (of what) _____ No _____

I am allergic to contrast dye used for imaging: _____ Yes _____ No _____ Unknown

REVIEW OF CURRENT SYSTEMS:

- Back problems, poor posture, arthritis. Recent or sudden weight loss, fever, chills, weakness or fatigue.
- Recent or sudden difficulty concentrating or memory issues. Recent headache, dizziness or syncope.
- Recent or sudden change in smell, vision or hearing. Recent or current enlarged lymph nodes.
- Recent unexplained skin rash or itching. Recent sweating, cold or heat intolerance.
- Recent anemia, bleeding or sudden unexplained or excessive bruising.
- Recent or sudden shortness of breath, coughing, chest pain/pressure/discomfort or heart palpitations.
- Recent food sensitivities, nausea, vomiting, diarrhea, abdominal pain or bloody stool.
- Recent burning on urination, change in bowel or bladder control.

PAIN TREATMENTS: Please check your response to the treatments you have tried.

TREATMENT	NEVER TRIED	NO RELIEF	MILD RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
SURGERY					
TRACTION					
INJECTIONS					
PHYSICAL THERAPY					
ACUPUNCTURE					
CHIROPRACTIC					
MASSAGE THERAPY					

My pain medications provide relief: None Some Most All of the time Not Applicable

CURRENT MEDICATIONS or SUPPLEMENTS:

Name	Dose / Frequency	Reason

Do you take Blood thinners ie. Aspirin, Plavix or Coumadin? _____ Yes _____ No

Date: _____ Name: _____ DOB: _____

PAST SURGICAL HISTORY:

DATE	TYPE OF OPERATION AND OUTCOME OF THE SURGERY

PAST MEDICAL HISTORY:

Have you had any of the following health problems (please check all that apply)?

- | | | |
|---|---|---|
| <input type="checkbox"/> Angina or chest pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Attacks / TIAs | <input type="checkbox"/> Lyme's Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis / Liver Problems | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Bleeding/Clotting Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Weight Loss Resistance |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Spine Trauma | <input type="checkbox"/> |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Cancer- specify type _____ | |

SOCIAL HISTORY:

Do you smoke/ chew / Vape nicotine ? Yes _____ /day No -In the Past No- Not ever

Do you use Marijuana products? Yes _____ /day Type: _____ No - Not ever

How much alcohol do you drink on a weekly basis? _____ Yes - In Past No - Never

How much caffeine do you drink daily? _____

Hand Dominance: Right _____ Left _____ Ambidextrous (Equal) _____

Your Height: _____ Your Current Weight: _____ Your Ideal Weight: _____

SUBSTANCE ABUSE:

Do you have a history of alcoholism? Yes No Current Problem

Cocaine or intravenous substance abuse? Yes No Current Problem

Have you abused prescription pain meds? Yes No Current Problem

How many years has it been since you abused alcohol or drugs? _____ years Not Applicable

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications, if any

Date: _____ Name: _____ DOB: _____

IMMEDIATE FAMILY HISTORY:

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your immediate blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Rheumatoid, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes, Clotting	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	

PSYCHOLOGICAL TREATMENT:

Have you ever had psychiatric evaluation or treatments for any problem? Yes No
 For what diagnosis were you treated? _____ When? _____
 Please list your current or last therapists: _____
 Have you ever considered suicide? Yes No When? _____

Additional Complaints/Symptoms/Conditions/Notes:
