Name_____ Date _____ Birthdate _____

Age _____ Sex: M ____ F ____ Height: _____ft. _____ in. Weight _____ lbs

Referring Physician_____ **Primary Physician (Full Name)** _____

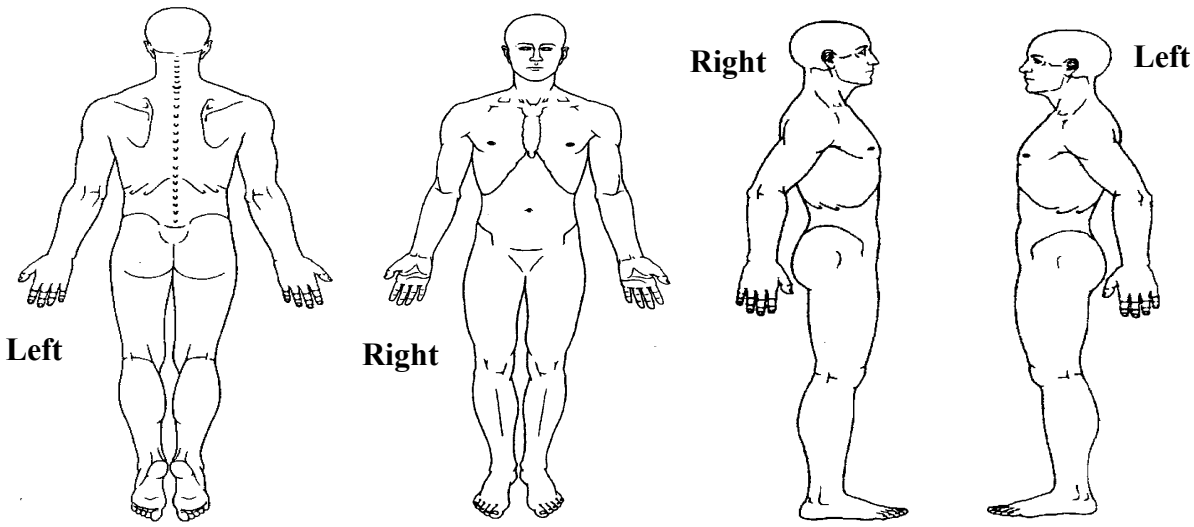
List all other physicians involved in your care and their specialty.

_____

What is your occupation? _____

Section 1

Please **draw** where your pain **primarily located** (Please use following diagram.)



Section 2

Please list ALL medications you are currently taking. Include vitamins, over-the-counter medications, herbal preparations, laxatives, or inhalers.

Include medication name, dose *AND* frequency

1._____ **8.**_____

2. _____ **9.**_____

3. _____**10.**_____

4. _____**11.**_____

5._____ **12.**_____

6. _____ **13.**_____

7. _____ **14.**_____

Do you currently have or are you being treated for an infection of any kind? If yes, please explain:

_____

_____

Is there any chance you could be pregnant? _____

Have you had a flu shot in the past 2 weeks? _____

Do you have any allergies to any medications, latex, iodine, contrast dye, or tape?

Yes__ No __

Please list Allergies to Medications and Reactions:

_____

Section 3 Preventative Health Questions

1. **Have you ever had a flu shot? If so, what month was your most recent flu shot done? _____**
2. **Have you ever had a pneumonia vaccination (shot)? If so, what year? _____**
3. **Have you ever had a mammogram? If so, what year was your most recent mammogram done? _____**
4. **Have you ever had a colorectal screening? If yes, what year was your most recent screening? _____ What type of screening was performed (colonoscopy or occult blood test? _____**

Have you had any of the following testing performed?

	Yes/No	Date(s)
MRI		
EMG		
CT SCAN		
Myelogram		

Have you had any of the following treatment performed?

	Yes/No	Date(s)	Did this treatment help your pain?
Physical Therapy			
Home Exercise Therapy			
Chiropractic Treatment			
Pain Injections/Blocks			
Traction			

What medications have you tried for this pain: _____

_____

Please rate your pain- **Please mark your average (A) pain and your maximum (M) pain on the line below:**

0 1 2 3 4 5 6 7 8 9 10
No Pain____I_____I_____I____I____I____I____I____I____I____I____ Worst Pain Imaginable

Please rate your pain as of right now from 0-10: _____

Please <u>circle</u> any of the following activities of daily living that you have had difficulty doing because of your pain:

Using the toilet Dressing Bathing Eating
Getting up from a bed or chair
If you have experienced <u>NO</u> difficulty with the above activities of daily living please check this box: □

Do you need any assistance walking? Yes ____ No_____
If so, what type?_____

Section 4
<u>Review of Systems:</u>

<u>General:</u>
__ Night Sweats
__ Appetite Loss
__Fatigue, lack of energy
__Fever/chills
__Weight loss > 10 pounds
__Weight gain >10 pounds

<u>Respiratory</u>
__Wheezing/Coughing

<u>Musculoskeletal</u>
__Joint Pain
__Joint Stiffness

<u>Cardiovascular</u>
__Chest Pain
__ Irregular heartbeat
__Palpitations
__Shortness of Breath
__Swelling of extremities

<u>Neurological</u>
__ Fainting/Black Outs
__ Seizures
__ Tremor

<u>Psychiatric</u>
__Anxiety
__Depression

<u>Skin:</u>
__Rash/Itching

<u>Endocrine</u>
__Cold Intolerance
__Heat Intolerance

<u>Hematology</u>
__Easy Bruising
__Abnormal Bleeding

<u>HEENT</u>
__Deafness
__ Glasses/Contacts
__ Glaucoma/Cataracts
__ Headaches
__ Hearing Loss
__ Nosebleeds
__Sinus Problems

<u>Gastrointestinal</u>
___abdominal pain
___Constipation
___Diarrhea
___Heartburn
___Nausea
____**ANY NEW ONSET OF BOWEL/BLADDER INCONTIENCE**

___All others Negative

Comments: (Explain anything marked above, if necessary:
_____
_____

Section 5

Past Medical History

Please mark any health problem you have had in the past

__Asthma
__Bronchitis
__Cancer Type: _____
__Ulcers
__Liver Disease
__High Blood Pressure
__ Atrial Fibrillation
__Pacemaker (___ year)
__Sleep Apnea
___Infectious condition, (i.e. Hepatitis)
___Kidney Disease
__Heart Disease
__Circulation Problem
__Congestive Heart Failure
___Mental Disorder
___Hypo/Hyper Thyroid
___Diabetes
___Fibromyalgia
__Neuropathy
__Stroke/TIA
__Kidney Infections
__Heart Failure
__Gastritis
__Depression
___Migraines
__Glaucoma

Have you had any neck (cervical), mid-back (thoracic), or low back (lumbar) surgery? If so, please list:

Date: _____ Surgery: _____ Surgeon: _____

Date: _____Surgery: _____Surgeon: _____

____Check here if no previous spine surgery

Tobacco Use:

Currently: Packs/Day_____ Number of Years_____

Previously: Packs/Day_____ Number of Years_____

If you have quit smoking, how long ago? _____

Alcohol Use_____ Amount per Week

Family History

Does your mother and/or father have the following health conditions?

____Diabetes _____Heart Disease ____Cancer

Form completed by: _____

Name of who will drive you home today _____

Office use only:_____

Form Reviewed

_____ M.D. Date _____ _____ R.N. Date_____

_____M.D. Date _____ _____ R.N. Date_____