

PLEASE USE BLUE OR BLACK INK ONLY

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Height: _____ ft _____ in Weight: _____ lbs

Primary Doctor Name and Address: _____ Referring Doctor Name and Address: _____

If not referred, how did you choose this office? _____

Why are you seeing the doctor today? _____

How long has the pain/problem been present? _____

Has the pain/problem worsened recently? No Yes, how recently? _____

What started the pain/problem? _____

Quality of the pain Sharp Burning Dull Aching

How severe is the pain at the location described above?

No Pain Mild Moderate Severe

What makes the pain/problem better? _____

What makes the pain/problem worse? _____

Is the pain (*check all that apply*): Continuous Activity related Night pain Unpredictable

Did this problem start at work? _____

Have you already filed or will you file a Workers' Compensation claim? _____

Have you missed work because of this problem? _____

What other treatments have you tried?

- | | | | |
|--|------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Physical Therapy/Exercise | <input type="checkbox"/> TENS unit | <input type="checkbox"/> Narcotic medications | <input type="checkbox"/> Cast/boot |
| <input type="checkbox"/> Massage/Ultrasound | <input type="checkbox"/> Traction | <input type="checkbox"/> Anti-Inflammatories | <input type="checkbox"/> Orthotics |
| <input type="checkbox"/> Manipulation | <input type="checkbox"/> Surgery | <input type="checkbox"/> Steroid injections | <input type="checkbox"/> Braces |

Previous physicians seen for this problem

Physician	Specialty	City	Treatment



Name of Patient: _____ Date of Birth: _____

Medications taken for this problem

Name of Medication	Dose	Reason

X-Rays and Tests for this problem:

	Results	Date	Location
<input type="checkbox"/> X-Rays			
<input type="checkbox"/> MRI			
<input type="checkbox"/> CT Scan			
<input type="checkbox"/> Bone Scan			
<input type="checkbox"/> Other			

Because of this problem, have you filed or do you plan to file a lawsuit? Yes No

If you have previously completed a *Comprehensive Health History* during a visit to our practice, have there been any changes to your medical history, surgical history or medications since that time? Please describe any changes below:

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I have read and confirmed the above information with the patient/family:

Provider Signature: _____ Date: _____



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Primary Doctor Name and Address:

Preferred Pharmacy (Address/Phone):

MEDICATIONS (*prescribed and over the counter*): *I take no medications*

Name of Medication	Dose	Reason

ALLERGIES (*i.e. medications, foods, other*) *No Allergies*

Name of Allergy	Reaction (rash, swelling, stomach upset, etc.)

METAL ALLERGIES: *No Allergies* Yes _____ (List Metals)



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MEDICAL HISTORY: Check all that apply **None Apply**

- | <u>PAST</u> <u>CURRENT</u> | <u>PAST</u> <u>CURRENT</u> |
|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Attention-deficit/hyperactivity (ADD/ADHD) | <input type="checkbox"/> <input type="checkbox"/> Hypertension / high blood pressure |
| <input type="checkbox"/> <input type="checkbox"/> Addiction/ alcoholism/substance abuse | <input type="checkbox"/> <input type="checkbox"/> Inflammatory bowel disease (ulcerative colitis/ Crohn's) |
| <input type="checkbox"/> <input type="checkbox"/> Anemia (low blood count) | <input type="checkbox"/> <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> <input type="checkbox"/> Anxiety | <input type="checkbox"/> <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis (i.e., osteoarthritis) | <input type="checkbox"/> <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> <input type="checkbox"/> Migraines / headaches |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding disorder _____ | <input type="checkbox"/> <input type="checkbox"/> MRSA infection / colonization |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Myocardial infarction (MI) (heart attack) |
| Type/treatment: _____ | <input type="checkbox"/> <input type="checkbox"/> Nerve / muscle disease _____ |
| <input type="checkbox"/> <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> <input type="checkbox"/> Neurofibromatosis |
| <input type="checkbox"/> <input type="checkbox"/> Congestive heart failure (CHF) | <input type="checkbox"/> <input type="checkbox"/> Neuropathy (peripheral): |
| <input type="checkbox"/> <input type="checkbox"/> Cirrhosis of the liver | <input type="checkbox"/> Hands / <input type="checkbox"/> Feet |
| <input type="checkbox"/> <input type="checkbox"/> Clotting disorder (blood clotting problem) | <input type="checkbox"/> <input type="checkbox"/> Obesity |
| <input type="checkbox"/> <input type="checkbox"/> Coombs positive | <input type="checkbox"/> <input type="checkbox"/> Osteomyelitis (bone infection) |
| <input type="checkbox"/> <input type="checkbox"/> Deep vein thrombosis (DVT) (blood clot in legs) | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis/ osteopenia |
| <input type="checkbox"/> <input type="checkbox"/> Dementia | <input type="checkbox"/> <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> Pulmonary embolism (lung blood clot) |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes: year diagnosed: _____ | <input type="checkbox"/> <input type="checkbox"/> Peripheral vascular disease (PVD) |
| Currently controlled with | <input type="checkbox"/> <input type="checkbox"/> Raynaud's phenomenon / disease |
| <input type="checkbox"/> Insulin <input type="checkbox"/> Oral medications <input type="checkbox"/> Diet | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> <input type="checkbox"/> Diabetic neuropathy: | <input type="checkbox"/> <input type="checkbox"/> Seasonal Allergies (allergic rhinitis) |
| <input type="checkbox"/> Hands / <input type="checkbox"/> Feet | <input type="checkbox"/> <input type="checkbox"/> Seizures |
| <input type="checkbox"/> <input type="checkbox"/> Down syndrome | <input type="checkbox"/> <input type="checkbox"/> Sickle cell anemia / trait |
| <input type="checkbox"/> <input type="checkbox"/> Emphysema (COPD) | <input type="checkbox"/> <input type="checkbox"/> Sleep apnea / obstructive |
| <input type="checkbox"/> <input type="checkbox"/> Gastric reflux/ GERD | <input type="checkbox"/> <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> <input type="checkbox"/> Gout | <input type="checkbox"/> <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> <input type="checkbox"/> Heart murmur | <input type="checkbox"/> <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> <input type="checkbox"/> Heart valve problem | <input type="checkbox"/> <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> <input type="checkbox"/> Hepatitis (A, B, or C) | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> <input type="checkbox"/> Ulcers (GI) |
| <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> <input type="checkbox"/> Urinary tract infection (UTI / bladder infection) |
| <input type="checkbox"/> <input type="checkbox"/> Hypercholesterolemia (high cholesterol) | |

Other: _____



Name: _____ Date of Birth: _____

PAST SURGICAL HISTORY: *No Prior Surgery*

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia? No Yes

If YES, have you had any problems related to this? No Yes

Please explain any problems related to general anesthesia: _____

SOCIAL HISTORY:

Work status:

Working Homemaker Unemployed Disabled On leave Retired Student

Occupation _____

Marital Status: Single Married Divorced Widowed

Children No Yes, How Many? _____

Do you live alone? _____ If no, who lives with you? _____

Are you currently smoking? _____ If yes, how many packs a day? _____ For how many years? _____

Have you quit smoking? If so, when did you quit? _____ How many years did you smoke? _____

How many packs a day did you previously smoke? _____ Other forms of tobacco? _____

Alcohol Use Never Rare Social Frequently (more than twice a week)
 Alcoholic Recovering Alcoholic

Illegal Drug Use Never In the past Currently Types of Drugs _____



Name: _____ Date of Birth: _____

FAMILY HISTORY: Check all that apply None apply

	Mother	Father	Sister	Brother	Daughter	Son	Other (Grandparent, etc) (Specify) _____
Alcoholism							
Arthritis							
Blood Clots							
Cancer							
Diabetes							
Heart Disease							
High Blood Pressure							
Gout							
Kidney Problems							
Kyphosis							
Lung Problems							
Mental Illness							
Scoliosis							
Spondylolisthesis							
Seizures							
Stroke							
Bleeding Problems							
Other _____							

Other Family History: _____



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REVIEW OF SYSTEMS: (in the past 30 days have you experienced any of the following?)

Constitution

- Fever
- Chills
- Weight loss
- Malaise/Fatigue
- Diaphoresis (excessive sweating)
- Weakness

Skin

- Rash
- Itching

Head/Ear/Nose/Throat (ENT)

- Hearing loss
- Tinnitus (ringing in ears)
- Ear pain
- Ear discharge
- Nosebleeds
- Congestion
- Sinus pain
- Stridor (noisy breathing)
- Sore throat

Eyes

- Blurred vision
- Double vision
- Photophobia (light sensitivity)
- Eye pain
- Eye discharge
- Eye redness

Cardiovascular

- Chest pain
- Palpitations
- Orthopnea (shortness of breath when lying down)
- Claudication (pain or cramping in legs)
- Leg swelling
- Paroxysmal nocturnal dyspnea (PND, shortness of breath/coughing at night)

Respiratory

- Cough
- Hemoptysis (coughing up blood)
- Sputum production (coughing up mucus/phlegm)
- Shortness of breath
- Wheezing

GI

- Heartburn
- Nausea
- Vomiting
- Abdominal pain
- Diarrhea
- Constipation
- Blood in stool
- Melena (dark/black stool)

Genitourinary (GU)

- Dysuria (pain, burning, or discomfort upon urination)
- Urgency
- Frequency
- Hematuria (pink, red or cola-colored urine)
- Flank pain

Musculoskeletal

- Myalgias (muscle pain)
- Neck pain
- Back pain
- Joint swelling
- Falls

Endocrine/Hematology/Allergy

- Easy bruise/bleed
- Environmental allergies
- Polydipsia (excessive thirst)

Neurological

- Dizziness
- Headaches
- Tingling
- Tremor
- Sensory change
- Speech change
- Focal weakness
- Seizures
- Loss of consciousness (LOC)

Behavioral

- Depression
- Suicidal ideas
- Substance abuse
- Hallucinations
- Nervous/anxious
- Insomnia
- Memory loss

I have not experienced any of the above symptoms in the last 30 days

Other: _____

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