

**PATIENT INFORMATION**

Primary Reason For Your Visit? \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_

Ethnicity:  Caucasian  African American  Asian  Hispanic

Referring Doctor: \_\_\_\_\_ Primary Doctor: \_\_\_\_\_

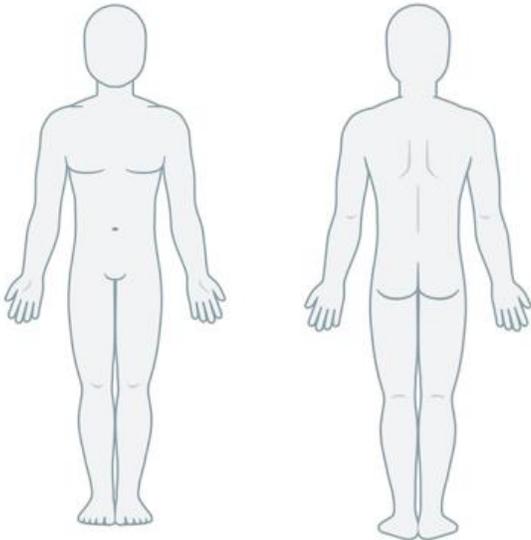
Primary Insurance: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

**SYMPTOMS** Describe your symptoms. Please fill out and use the diagram below to assist you in your description.

Mark on the drawings according to where you hurt. Please indicate on the drawing where you feel any of the following symptoms by placing the marks shown here on the DIAGRAM KEY.

**DIAGRAM KEY**

Numbness=**N** Ache=**A** Weakness=**W**  
 Burning=**B** Stabbing=**S** Pins & Needles=**P**


**FOR OFFICE USE ONLY**

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_

Pulse: \_\_\_\_\_

O2 Sat (%) \_\_\_\_\_

**How Long Have You Had These Symptoms?** \_\_\_\_\_

 Have you **EVER** had any of these symptoms in the past? Yes No

 Pain Score on your **WORST** day (0=no pain to 10=worst)? \_\_\_\_\_

 Do you have any weakness? Yes No

Where: \_\_\_\_\_

 Do you have numbness/tingling? Yes No

Where: \_\_\_\_\_

**What Makes Your Pain Better?**
Laying Sitting Standing Walking Rest Heat

Ice Position Change NSAIDs (Ibuprofen, Celebrex, etc.)

Narcotics (name): \_\_\_\_\_

**What Makes Your Pain Worse?**
Laying Sitting Standing Walking Twisting Lifting

Pushing/Pulling Sit to stand Getting out of bed Carrying

**Previously Tried Treatment(s):**
**\*Physical Therapy** No Yes (When?) \_\_\_\_\_ Was it helpful? \_\_\_\_\_

Provider name and office: \_\_\_\_\_

What area were you being treated for? \_\_\_\_\_

**\*Steroid Injections** No Yes (When?) \_\_\_\_\_ Was it helpful? \_\_\_\_\_

Provider name and office: \_\_\_\_\_

Location of Injection: \_\_\_\_\_

**\*Stimulator** No Yes (When?) \_\_\_\_\_ Was it helpful? \_\_\_\_\_

 Type: Spinal Peripheral

Provider name and office: \_\_\_\_\_

**\*Opioid Pain Pump** No Yes (When?) \_\_\_\_\_ Was it helpful? \_\_\_\_\_

Provider name and office: \_\_\_\_\_

**Other Therapies:**
Chiropractic Massage At Home Exercises Aquatic Acupuncture

## MEDICAL HISTORY (Check ALL That Apply)

<input type="checkbox"/> Alzheimer's (Dementia) <input type="checkbox"/> Atrial Fibrillation _____(YEAR) <input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Aortic Aneurysm _____(YEAR) <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Brain Aneurysm <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Back Problems <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> CAD <input type="checkbox"/> COPD _____(YEAR) <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Chronic Long Term Infection/Disease <input type="checkbox"/> Depression <input type="checkbox"/> DVT <input type="checkbox"/> Diabetes-Type:____ <input type="checkbox"/> GERD <input type="checkbox"/> GOUT <input type="checkbox"/> HIV or AIDS <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Head Trauma/Injury <input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Heart Attack (MI) _____(YEAR) <input type="checkbox"/> Heat Stroke <input type="checkbox"/> Hepatitis B _C (circle one) <input type="checkbox"/> Hypertension <input type="checkbox"/> Hernia	<input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Liver Disease <input type="checkbox"/> Lung Disease <input type="checkbox"/> Multiple Sclerosis _____(YEAR) <input type="checkbox"/> Mechanical Heart Valve <input type="checkbox"/> MRSA _____(YEAR) <input type="checkbox"/> Muscle/Joint/Bone Pain <input type="checkbox"/> Motion Sickness <input type="checkbox"/> Neck Injury <input type="checkbox"/> Neuropathy <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker/AICD _____(YEAR) <input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Pulmonary Embolism _____(YEAR) <input type="checkbox"/> PTSD <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Seizure/Epilepsy <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Snoring <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Stroke _____(YEAR) <input type="checkbox"/> TIA _____(YEAR) <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Thyroid Problems _____ <input type="checkbox"/> TMJ <input type="checkbox"/> Urinary Tract Infections <input type="checkbox"/> Urinary Retention <input type="checkbox"/> Other _____ _____
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## SURGICAL HISTORY- LIST PAST SURGERIES OF ANY KIND

Have you had any of the following:  Hysterectomy  Tubal Ligation | Are you currently Pregnant?  Yes  No

Surgery: \_\_\_\_\_ Date: \_\_\_\_\_ MD Name: \_\_\_\_\_

## YOUR CURRENT SYMPTOMS (Check ALL That Apply)

<input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Numbness in the genitals <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Seizures <input type="checkbox"/> Headaches <input type="checkbox"/> Change of vision <input type="checkbox"/> Depression <input type="checkbox"/> Nervousness <input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Environmental allergies <input type="checkbox"/> Heat or cold intolerance	<input type="checkbox"/> Chronic cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Voice changes <input type="checkbox"/> Chronic sinus problems <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Frequent diarrhea <input type="checkbox"/> Severe heartburn <input type="checkbox"/> Constipation <input type="checkbox"/> Excessive urination <input type="checkbox"/> Burning with urination	<input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Change in sexual function <input type="checkbox"/> Recurrent fever, chills, sweats <input type="checkbox"/> Recent weight loss <input type="checkbox"/> Enlarged lymph nodes <input type="checkbox"/> Extreme fatigue <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Easy bruising <input type="checkbox"/> Frequent bleeding <input type="checkbox"/> Abnormal mole <input type="checkbox"/> Skin rash <input type="checkbox"/> Other: _____
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## FAMILY HEALTH HISTORY Place the letter of your family member relationship that has a condition listed below.

M-Mother; F-Father; B-Brother; S-Sister; MGM-Maternal Grandmother; MGF-Maternal Grandfather; PGM-Paternal Grandmother; PGF-Paternal Grandfather

Addiction \_\_\_\_\_ Heart Attack \_\_\_\_\_ Cancer \_\_\_\_\_ Osteoporosis \_\_\_\_\_ Pulmonary Embolism \_\_\_\_\_

Hypertension \_\_\_\_\_ Rheumatoid Arthritis \_\_\_\_\_ Multiple Sclerosis \_\_\_\_\_ Diabetes \_\_\_\_\_ TMJ \_\_\_\_\_

Back Problems \_\_\_\_\_ Bleeding Disorder \_\_\_\_\_ Alzheimer's \_\_\_\_\_ Stroke \_\_\_\_\_ Unknown (Adopted) \_\_\_\_\_

Is this the result of a specific injury or accident?  Yes  No | Date of accident: \_\_\_\_\_

Describe Accident: \_\_\_\_\_

Are you involved in litigation regarding this condition?  Yes  No | Type of accident: \_\_\_\_\_

## CARDIOLOGY-HEART

Have you **EVER** been seen for a heart-related problem? Yes No | If yes, what for: \_\_\_\_\_

If yes, please provide name and office/location: \_\_\_\_\_

Date of last EKG: \_\_\_\_\_ | Do you have a: Stent | Pacemaker | Artificial Heart Valve | Heart Arrhythmia (circle all that apply)

Have you ever had Heart surgery? Yes No | If yes, when: \_\_\_\_\_

Who manages your heart medications? Cardiologist Primary Care Provider

Have you had any of the following in the last 6 months? Chest Pain Shortness of Breath A-Fib Palpitations

## SOCIAL HISTORY

Tobacco Use: Yes No \_\_\_\_\_ # packs per day | What age/year did you start smoking? \_\_\_\_\_

Former Smoker? Yes No | How long ago did you quit? \_\_\_\_\_

Recreational Drug Use: Yes No | How often and what substance? \_\_\_\_\_

Alcohol Use: Yes No \_\_\_ # drinks per Day Week Month | Do You Drink Caffeine: Yes No

Exercise: Occasional Moderate Frequent Stopped Due to Pain None

Relationship Status: Married Single Widow | Hand Dominance: Right Left Ambidextrous

Do You Live Alone? Yes No | Will You Have Help After Surgery? Yes No

## OTHER

- Do you use any of the following devices: NONE Wheelchair Walker Crutches Cane Other \_\_\_\_\_
- Do you have any loose teeth: Yes No
- Do you wear dentures: Yes No | IF Yes, is it a partial: Yes No
- Do you have any of the following: NONE CPAP BiPAP | IF yes, do you use it as directed: Yes No
- Do you experience Nausea/Vomiting after surgery? Yes No
- Have you been told you are difficult to intubate for surgery? Yes No
- When getting an IV, have you **EVER** had a machine/device used on you to place the IV? Yes No \_\_\_\_\_
- Do you have an insulin pump Yes No
- Do you have any bleeding disorders? Yes No | If Yes please list type: \_\_\_\_\_
- Have you ever had Radiation to your throat or mouth? Yes No | If Yes please list type: \_\_\_\_\_

## MEDICATIONS/ALLERGIES *PLEASE BRING A LIST OF CURRENT MEDICATIONS TO APPOINTMENT*

Are you on any blood thinning medications? Aspirin Plavix Coumadin Xarelto Eliquis Pradaxa Effient

Other: \_\_\_\_\_

Have you taken any of the following medications in the last **SIX MONTHS**? Please check **ALL** that apply:

Ibuprofen (Advil, Motrin) Aspirin (Bayer, Excedrin, Generic) Naproxen (Aleve, Midol, Naprosyn) Gabapentin

Meloxicam (Mobic) Toradol Celebrex Voltaren Weight Loss Medication (Injectable) Anti-Depressant

Soma Baclofen Flexeril Tizanidine **OTHER:** \_\_\_\_\_

**ALLERGIES:**

I attest that all information provided is true and correct to the best of my knowledge.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

