

Name _____ Age _____ Ht _____ Wt _____
 Reason For Today's Visit _____
 Date of Injury/Onset _____ Where _____
 Are You Working Now? Y N Date Last Worked _____ Occupation _____
 How Did This Happen? _____

Please Leave This
 Column Blank for
 Physician Comments

ALLERGIES: (Please indicate your reaction to the right of the medication)

___ None _____ ___ Demerol _____ ___ Penicillin _____
 ___ Anesthesia _____ ___ Erythromycin _____ ___ Sulfa _____
 ___ Aspirin _____ ___ Iodine _____
 ___ Codeine _____ ___ Morphine _____

Other _____

MEDICATIONS (Presently Taking): _____

YOUR MEDICAL HISTORY:

___ Aids/HIV	___ Epilepsy/Seizures	___ Infections
___ Anemia	___ Emphysema	___ Kidney Disease
___ Arthritis	___ Gout	___ Meningitis
___ Back Problems	___ Heart Disease	___ Migraine Headaches
___ Bleeding Disorder	___ Heart Murmur	___ Nervous Breakdown
___ Bone Disease	___ Herpes/Shingles	___ Neurologic Disease
___ Bronchitis	___ Hepatitis/Jaundice	___ Rheumatic Fever
___ Cancer	___ Hiatal Hernia/Reflux	___ Sleep Apnea – CPAP?
___ Diabetes	___ High Blood Pressure	___ Tuberculosis
		___ Ulcers

Other: _____

SURGICAL HISTORY:

Type of Surgery	Date	Where	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REVIEW OF SYSTEMS:

Any numbness, tingling, burning, or other nerve problem? _____
 Any fever, chills, appetite loss, unexpected weight loss? _____

FAMILY HISTORY (i.e.: heart problems, diabetes, high blood pressure, cancer):

SOCIAL HISTORY: Do you smoke? Yes No If so, how much? _____
 Do you drink alcohol? Yes No If so, how much? _____

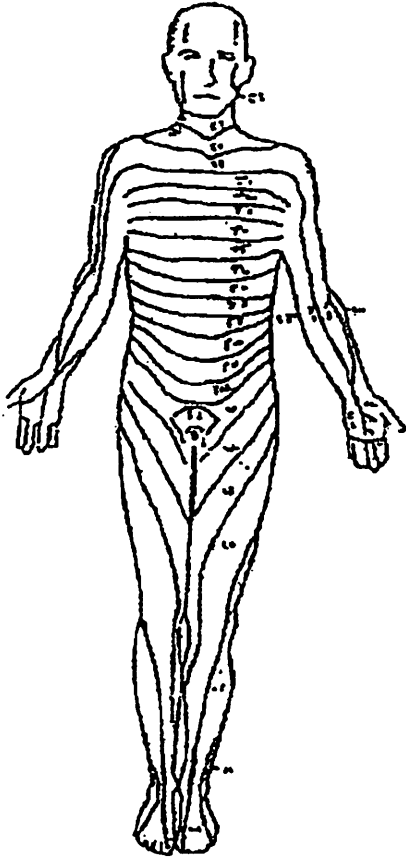
This document reviewed by _____, M.D. on _____
 (Date)

Updated by patient _____ on _____
 (Date)

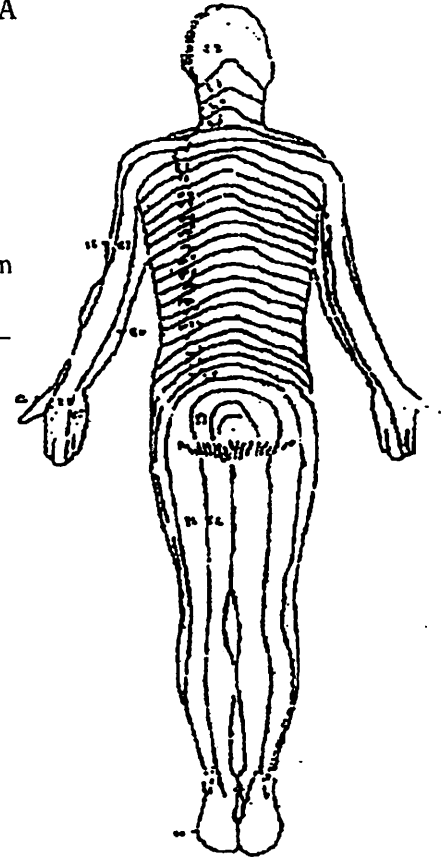
TO BE COMPLETED BY PATIENT

NAME _____ DATE _____

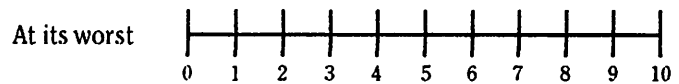
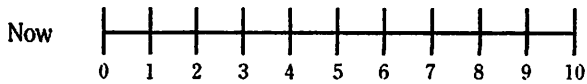
PAIN LOCATION -- SHADE IN PAINFUL AREA
WHICH WORDS DESCRIBE YOUR PROBLEM
PLEASE CHECK (✓)



- Ache Burning Hot
- Pins / Needles Stabbing Cold
- Numbness Pressure Vibration
- Other _____



On a Scale of 0 (no pain) to 10 (worst possible pain) how bad is your pain:



Is the pain in your arm(s):

- Worse than your neck _____
- Same as your neck _____
- Less than your neck _____

For A 100% Total Neck Pain _____ %

Please Divide Your Pain Arm Pain _____ %

Is the pain in your leg(s):

- Worse than your back _____
- Same as your back _____
- Less than your back _____

For A 100% Total Back Pain _____ %

Please Divide Your Pain Leg Pain _____ %

How long can you:

Sit? _____ minutes

Stand? _____ minutes

Ride in Car _____ minutes

How far can you walk _____ blocks

Please List Any Activities That Make Your Problem:

Worse _____

Better _____

Patient / Guarantor Signature _____