1206D-2313

Patient Name: _____ Date of Birth: _____ Date: _____
Age: _____ Gender: ☐ M ☐ F
Occupation: _____
Hand Dexterity: ☐ Right ☐ Left ☐ Ambidextrous

Please check the box that best applies to you (check only one box):

☐ I am here today because I was referred by a physician for consultation.
Physician Name: _____ Telephone: (_____) _____
Office Address: _____ Fax: (_____) _____
City: _____ State: _____ Zip: _____

OR

☐ I am here today because I was self-referred patient for a second opinion.
Please provide the name and address of any other physician to whom you would like us to send a report:
Physician Name: _____ Telephone: (_____) _____
Office Address: _____ Fax: (_____) _____
City: _____ State: _____ Zip: _____

Chief Complaint (Check):

☐ Upper ☐ Mid ☐ Lower Back ☐ Legs ☐ Buttock ☐ Hip ☐ Ankle

☐ Right ☐ Left ☐ Both ☐ Neck ☐ Arms ☐ Wrist ☐ Hands ☐ Shoulder ☐ Elbow

Please describe your current symptoms and the duration (length of time) you have been experiencing them:

_____

_____

Surgical History (List all other surgeries you have had):

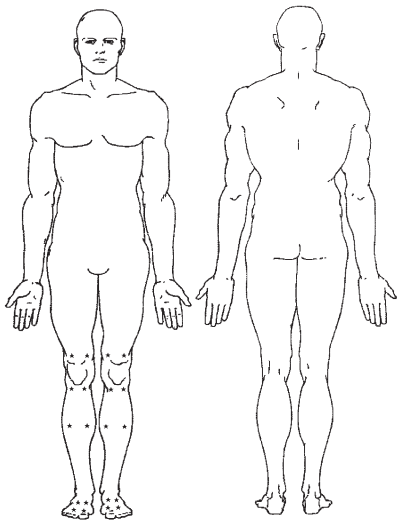
Year	Type of Surgery	Year	Type of Surgery

Complications (Check and explain any complications you have had after any of your surgeries):

	Infection:		Pneumonia:
	Bleeding:		Lung Problems:
	Blood Clot:		Severe Nausea/Vomiting:
	Anesthesia Reaction:		Other:

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol to indicate all affected areas.

NUMBNESS ------ PINS & NEEDLES 000000 BURNING XXXXXX STABBING //////



Motor Vehicle Accident?	☐ Yes	☐ No	Date of Accident: _____
Work Related?	☐ Yes	☐ No	Employer: _____
LEGAL Actions pending?	☐ Yes	☐ No	Filed on what day: _____
Are you working now?	☐ Yes	☐ No	Last Day Worked: _____

What is your **pain level** on a scale from 0 to 10 (0 = NO Pain, 10 = Worst Pain Imaginable)? _____

How far are you able to walk without your symptoms causing you to stop and rest?

_____

Do you use any devices to help with walking? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Motorized Scooter

Aggravating Factors: ☐ Lifting ☐ Coughing ☐ Sneezing ☐ Standing ☐ Walking ☐ Sitting ☐ Climbing Stairs

The pain is described as: ☐ Constant ☐ Intermittent ☐ Unchanged ☐ Worse ☐ Better

Describe your pain: ☐ Burning ☐ Sharp-shooting ☐ Tingling ☐ Numbness ☐ Pinprick ☐ Stabbing ☐ Deep-pressure ☐ Tightness Spasms

Treatment & Evaluations: ☐ MRI ☐ X-Ray ☐ CT ☐ EMG ☐ Bone Scan ☐ Blood/Laboratory ☐ Epidurals

Have you tried any of the following treatments for pain?

☐ TENS ☐ Heating Pad ☐ Ice ☐ Exercise ☐ Inversion Table ☐ Surgery ☐ Medications ☐ Acupuncture ☐ Chiropractor

☐ Physical Therapy (PT) If yes, how many PT sessions have you had in the last year? _____. When was your last session? _____. Did the PT session help you? ☐ Yes ☐ No

☐ Injections/Epidurals If yes, how many Injections/Epidurals have you had in the last year? _____. When was your last Injections/Epidurals? _____. Did the Injections/Epidurals help you? ☐ Yes ☐ No

What makes pain worse? _____

What makes pain better? _____

How does the pain limit you? _____

Bowel or bladder problems? ☐ No ☐ Yes: Be specific: _____

_____

Have you had any problems with balance? ☐ No ☐ Yes

List all Medications you take regularly (include non-prescription meds): ☐ See Attached List

Name & Dose	How Often	Name & Dose	How Often

Have you taken any of the following medications in the past year?

☐ Pain Medications ☐ Nerve Medications ☐ Steroid ☐ NSAIDs (i.e., ibuprofen, Celebrex, Naprosyn)

If you checked one or more boxes, were these medications effective for you? ☐ Yes ☐ No

Allergies: ☐ No ☐ Yes If yes, please list medication and reaction to it below:

Medication	Reaction	Medication	Reaction

Social History:

Do you drink alcohol? ☐ No ☐ Yes If yes, what is the average of drinks per week: _____

Do you smoke? ☐ No ☐ Yes If yes, how many packs/day: _____ For how long: _____

Previous history ☐ No ☐ Yes If yes, for how many years: _____

Do you use drugs recreationally? ☐ No ☐ Yes If yes, what substance and how frequently: _____

Review of Symptoms: (Check any recent/current problems, check symptoms or write in other):

N	Y	System	Symptoms/Problems	Other
		General/Constitutional	☐ Fever, ☐ Unexplained Weight Loss/Gain, ☐ Weakness, ☐ Nausea, ☐ Vomiting	
		Eyes/Vision	☐ Glasses/Contacts, ☐ Blurred, ☐ Double, ☐ Dry Eyes, ☐ Visual Loss, ☐ Color Blindness, ☐ Glaucoma	
		Ears, Nose, Throat, Mouth	☐ Vertigo, ☐ Sinusitis, ☐ Hoarseness, ☐ Loss of Hearing, ☐ Post Nasal Drip	
		Cardiovascular	☐ Chest Pain, ☐ Murmurs, ☐ Palpitations, ☐ Irregular Rhythm, ☐ Arrhythmia	
		Respiratory	☐ Short of Breath, ☐ Asthma, ☐ Cough, ☐ Wheezing, ☐ Pneumonia, ☐ Tuberculosis	
		Digestive Tract	☐ Diarrhea, ☐ Constipation, ☐ Ulcers, ☐ GERD, ☐ Pain, ☐ Appetite Change, ☐ Jaundice, ☐ Hemorrhoids, ☐ Irritable Bowels	
		Kidney/Urinary	☐ Stones, ☐ Burning, ☐ Itching, ☐ Blood in Urine, ☐ Painful Urination, ☐ Impotence	
		Skin/Breast	☐ Rash, Lump, ☐ Itching, ☐ Hair or Nails Change, ☐ Easy Bruising/Bleeding	
		Endocrine	☐ Excess Thirst, ☐ Decreased Energy, ☐ Diabetes, ☐ Abnormal Growth, ☐ Goiter, ☐ Heat/Cold Intolerance	
		Neurologic	☐ Balance, ☐ Numbness/Tingling, ☐ Seizure, ☐ Tremor, ☐ Headaches, ☐ Paralysis	
		Psychiatric	☐ Depressions, ☐ Anxiety, ☐ Sleep Disorder, ☐ Hallucinations, ☐ Nervous Breakdown, ☐ Unhappy	
		Hematologic/ Lymphatic	☐ Blood Clots, ☐ Bleeding Problems, ☐ Easy Bruising, ☐ Transfusion, ☐ Enlargement Lymph Node, ☐ Pain, ☐ Swelling, ☐ Varicosities, ☐ Anemia, ☐ Blood Thinners	
		Musculoskeletal	☐ Fracture, ☐ Arthritis, ☐ Motion Loss, ☐ Cramps/Spasms, ☐ Dislocation, ☐ Muscle Weakness	
		Allergic/Immunologic	☐ Dermatitis, ☐ Hay Fever, ☐ Migraine, ☐ Sensitivity to Pollen	

Family History (Mark any conditions that your parents or siblings have or have had by indicating the family member [M = mother, F = Father, B = Brother, S = Sister] after the conditions):

High Blood Pressure:	Asthma:	Cancer:
Heart Attack:	Lung Disease:	Stroke:
Coronary Artery Disease:	Tuberculosis:	Diabetes:
Heart Valve Disease:	Thyroid Disease:	Kidney Disease:
Irregular Heart Rhythm:	Blood Clots:	Arthritis:
Peripheral Vascular Disease:	Seizures:	Osteoporosis:
Hepatitis: ☐ A ☐ B ☐ C	Immunodeficiency:	Other:

I certify that the foregoing statements are true to the best of my knowledge.

Patient Signature: _____ Date: _____ Time:

Vital Signs:

Temp: _____ BP: _____ HR: _____ RR:_____ Pain: _____ Height: _____ Weight: _____BMI: _____

Medical Assistant (Print): _____ (Signature): _____ Date: _____ Time: _____

PHYSICAL EXAMINATION:

Physician (Print): _____ (Signature): _____ Date: _____ Time: _____

PATIENT ID