Name________________________________ Today's Date_________________

Age ___________ Date of Birth______________ Height_________ Weight_________

Referring Doctor____

Address:____

________________________________ Phone______________________

Primary / Family Doctor:____

Address:____

________________________________ Phone______________________

If self-referral, how did you learn of our office?__________________________________

____

Medical History

Surgical history **Date**

1.____ ____________

2.____ ____________

3.____ ____________

4.____ ____________

5.____ ____________

Have you ever experienced problems with anesthesia? yes / no If yes, please explain:

____

Prescription Medications (please include dosage and frequency *and* include pain meds)

1.________________________________ 6.________________________________

2.________________________________ 7.________________________________

3.________________________________ 8.________________________________

4.________________________________ 9.________________________________

5.________________________________ 10._______________________________

***Blood Thinner**______________________ **Reason**____________________________

Nonprescription Medications

1.________________________________ 5.________________________________

2.________________________________ 6.________________________________

3.________________________________ 7.________________________________

4.________________________________ 8.________________________________

Name:______________________________

Drug/Food Allergies / Type of Reaction _____ NO ALLERGIES

1.____

2.____

3.____

Do you have an allergy to latex? YES NO or to tape adhesive? YES NO

ANY allergic reaction to IV dye, iodine, or shellfish? YES NO

Past and Current Medical Review (circle any problem you have or have had):

Cancer:	Type:________________		Treatment:________________		
Transmissible	TB	recent TB exposure	+TB test		
disease:	Hepatitis A	Hepatitis B	Hepatitis C	HIV+	AIDS
Constitutional:	recent fever	unexplained weight loss	fatigue	frequent illness	
Eye Problems:	blindness	cataracts	glaucoma	prosthetic eye	vision difficulty
	glasses	contacts			
Ear/Nose/Throat:	hearing loss	deaf	hearing aids	swallowing problems	
Cardiovascular:	angina/coronary artery disease	irregular heartbeat	atrial fibrillation	heart attack	
	heart murmur	rheumatic fever	heart surgery		
	high blood pressure	low blood pressure	blood vessel blockage	stent	
	implantable defib. device	pacemaker	congestive heart failure		
	valve replacement surgery / type__________				
Respiratory:	emphysema	COPD	asthma	sleep apnea	shortness of breath
Gastrointestinal:	ulcers	hemorrhoids	hiatal hernia	GERD	gallstones
	yellow jaundice	cirrhosis			
Musculoskeletal:	broken bones	muscular disorder	decrease in muscle size		
	connective tissue disorder	osteoporosis	fibromyalgia		
Skin:	changing moles	skin lesions	breast lump		
Neurological:	head injury	stroke/when_____	migraines	mute	
	speech difficulties	Parkinsons's	Alzheimer's	multiple sclerosis	
	epilepsy / seizures	ambidextrous	TIA/when_____		
Psychiatric:	nervous breakdown	depression	Schizophrenia	manic-depressive	anxiety
Endocrine:	hypothyroid	hyperthyroid	menstrual irregularity		
	diabetes – if yes, age of onset_____; controlled by	diet	oral agents	insulin	
Hematological:	swollen lymph nodes	anemia	transfusions	leukemia	
Abdomen / Pelvis:	kidney stone	kidney failure	hysterectomy	tubal ligation	
Other:	________________________________				

Name________________________________

Review of systems (circle any of the following you currently experience)

General	Eyes	Ear/Nose/Throat	Respiratory
weight loss	pain	sore throat	wheezing
weight gain	discharge	hoarseness	cough
fever	light sensitivity	ear ringing	shortness of breath
fatigue	blurred vision	nose bleeds	

Heart	G.I.	Urinary	Neurological
chest pain	abdominal pain	frequency	headache
fainting	blood in stool	hesitancy	confusion
feet swelling	vomiting	flank pain	numbness
palpitations	diarrhea	painful urination	slurred speech
		blood in urine	

Musculoskeletal	Skin/Breast	Endocrine	Blood/Lymphatic
joint swelling	rash	excess sweat	bleeding tendencies
joint redness	itching	excess thirst	lymph node swelling
joint pain	sores	excess hot	easy bruising
gait problems	abscess	excess cold	
	discharge		

Psychological

anxiety depression

severe stress panic

(___All other ROS WNL)

Are you Right or Left Handed? ______________________

Females

Are you pregnant: yes / no Date of last menstrual period : ___________

Males

Do you experience impotence: yes / no Erectile problems: yes / no

Are there any other problems we should be aware of?_____________________________

____

08-10-04

Name________________________________

Circle and date immunizations you have had

Flu ____________ Pneumonia______________ Others________________________

Social History (circle appropriate listings)

Tobacco Use	Alcohol Use	Drug Use	Marital Status
Never	none	marijuana	single
Quit date	socially	cocaine	married
________	daily	amphetamines	divorced
chewing tobacco	heavy	other________	widowed
pipe cigars		___________	children
cigarettes			
pack/day _____years______			

Have you ever been treated for alcoholism/drug addiction? yes / no If yes, please explain:____

Have you received psychological care for pain, depression, suicidal ideation, or any other nervous condition? yes / no If yes, please explain:______________________________

____

____

Family Health History (circle appropriate listings)

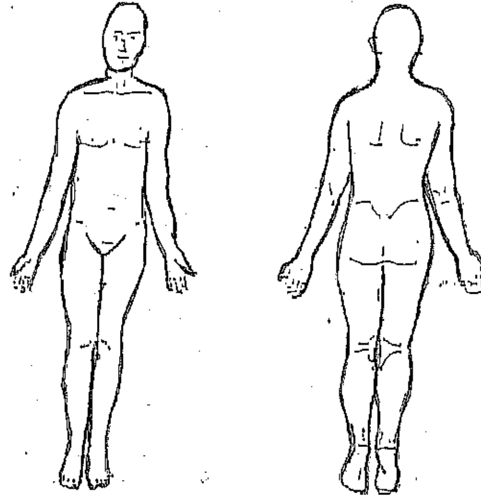
heart disease	diabetes	stroke	cancer	high blood pressure
muscular disease	epilepsy	TB	mental illness	connective tissue disease

08-10-04

Name_______________________________

History of Your Pain

On the drawings, please mark the areas where you feel pain. Put an "X" if external, or "I" if internal, near the areas which you mark.



Please describe how and when you first noticed the pain: ______________________

____

List things that make your pain worse: ______________________

____

List things that make your pain better: ______________________

____

List activities you are unable to do because of your pain: ______________________

____

Previous therapies/interventions:

Interventions	When	Relief (good, fair, poor)
Physical therapy		
Brace		
Chiropractor		
TENS		
Muscle Stimulator		
Traction		
Other		
Nerve Injections (type)		

Name:______________________

Occupational History

I am: employed full-time employed part-time a homemaker retired

currently unemployed a student other ______________

on disability – if so, for what condition? ______________________

Employer______________________ Job Title______________

Have you altered your job as a result of your pain? Yes / No

If yes, please explain:______________________________________

If currently off work, for how long? ______________

If appropriate, please circle the physical level of work your normal job involves:

	Sedentary	Light	Medium	Med/Heavy	Heavy	+Heavy
Occasional 0 – 33%	0 lbs	10 lbs	20 lbs	50 lbs	75 lbs	100+ lbs
Frequently 34 – 66%	0 lbs	10 lbs	20 lbs	50 lbs	75 lbs	100+ lbs
Constant 67 – 100%	0 lbs	10 lbs	20 lbs	50 lbs	75 lbs	100+ lbs

List any current work restrictions and the physician who implemented them:

____

____

____

For Office Use Only

This record of the patient's past medical history, surgical history, current medications, allergies, review of systems, family and social histories has been reviewed by me. This information is a permanent part of my consultation for this patient.

BP_________/_________P_________RR_________HT_________WT_______

Reviewed by____________________________________Date:______________

BP_________/_________P_________Reviewed By:______________________

Changes______________________________________Date:______________

BP_________/_________P_________Reviewed By:______________________

Changes______________________________________Date:______________

BP_________/_________P_________Reviewed By:______________________

Changes______________________________________Date:______________

BP_________/_________P_________Reviewed By:______________________

Changes______________________________________Date:______________

BP_________/_________P_________Reviewed By:______________________

Changes______________________________________Date:______________

BP_________/_________P_________Reviewed By:______________________

Changes______________________________________Date:______________

BP_________/_________P_________Reviewed By:______________________

Changes______________________________________Date:______________

BP_________/_________P_________Reviewed By:______________________

Changes______________________________________Date:______________

BP_________/_________P_________Reviewed By:______________________

Changes______________________________________Date:______________

BP_________/_________P_________Reviewed By:______________________

Changes______________________________________Date:______________

BP_________/_________P_________Reviewed By:______________________

Changes______________________________________Date:______________

BP_________/_________P_________Reviewed By:______________________

01-01-04