

For Office Use Only:

PRN: _____ Date: _____

Dr. Signature: _____

Today's Date: _____

1. GENERAL INFORMATION

Full Name: _____ Sex: M F
Date of Birth: ____ / ____ / ____ Age: _____ SS#: _____ - ____ - ____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home phone number: (____) _____ - _____ Cell phone number: (____) _____ - _____
Marital Status: Married Single Widowed Divorced Separated Partnered
Height: _____ Weight: _____ Exercise: Never Occasionally Frequently Regularly
Do you now or have you ever smoked? Yes No Do you drink alcohol? Yes No
What is your occupation? _____ Retired Disabled
Please name your **Primary Care Medical Doctor**: _____

You will be asked to present a valid ID prior to the Doctor consultation (i.e., Driver's license)

Doctor's use only – Do not write in this box.

Blood pressure: ____ / ____ Pulse Rate: ____ bpm

Temperature: _____ Respiration: _____ cpm

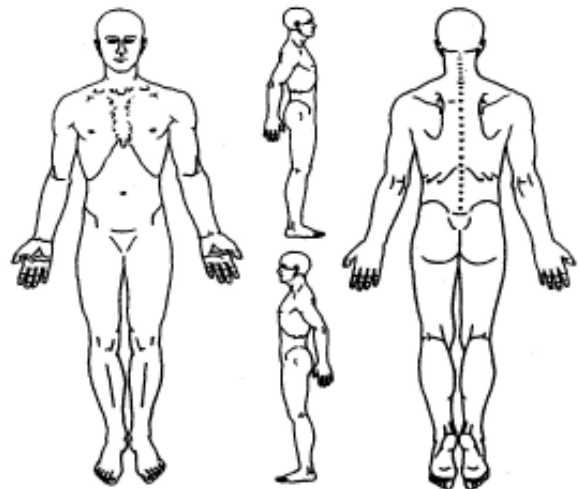
2. REASON FOR TODAY'S VISIT

What is the reason for your visit today?

Draw your pain on the diagram:

Indicate type of pain

- A = Achy
- B = Burning
- D = Dull achy
- N = Numb
- S = Sharp
- T = Tingling



When did the pain start (Date)? ____ / ____ / ____

My current pain/problem seems to be:

- Getting Better Staying the same Getting Worse

Did it come on gradually with no specific incident involved? Yes No

Did it come on suddenly? Yes No

Was there an accident involved or specific incident involved? (Lifting something etc...)

Explain: _____

If you have had this pain/problem before, what was the date of the first episode? _____

- How many episodes per year? _____ per month? _____ N/A

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Circle the intensity level of your pain:

MILD 1 2 3 4 5 6 7 8 9 10 **SEVERE**

What time of day is your current pain/problem worse?

Morning Afternoon Evening Middle of the night N/A

Percentage of the day you have this pain? 1-25% 26-50% 51-75% 76-100%

3. YOUR PAST GENERAL MEDICAL, SOCIAL, AND FAMILY HISTORY

Check off all that make the pain feel better:

- Sitting
- Standing
- Lying down
- Movement
- Rest
- Walking
- Working
- Mornings
- Evenings
- Nothing
- Daily activities (shopping, etc...)

Check off all that make the pain feel worse:

- Sitting
- Standing
- Lying down
- Movement
- Rest
- Walking
- Working
- Mornings
- Evenings
- Nothing
- Daily activities (shopping, etc...)

Which tests have you had for this condition?

- X-rays
- MRI
- CT scan
- Nerve conduction test
- Bone scan
- Lab work
- Video fluoroscope
- EMG
- Diagnostic ultrasound

What have you already tried for this problem?

- Anti-inflammatory
- Muscle relaxants
- Pain meds
- Pain injections
- Physical therapy
- Exercise
- Bed rest
- Acupuncture
- Massage
- Ice
- Heat
- Back brace
- Chiropractic adjusting
- Other Physician, please specify _____

Past surgeries/injuries/fractures (Dates): _____

Medications currently taking (reason for taking, dosage, doctor if prescribed): _____

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Currently or in the past have you suffered from:

- | | | |
|---|---|---|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Allergies | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Neurological disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Fractures (as above) | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Endocrine disease | |

Other disorders not mentioned above: _____

Do you have numbness in the groin or anal area? No Yes; for how long? _____

Have you experienced loss of bowel or bladder control (accidents)?

- No Yes; explain: _____

Have you noticed any progressive muscle weakness especially in your arms/legs?

- No Yes; for how long? _____

Is your pain/problem worse at night? No Yes

Does your current pain/problem awaken you after falling asleep? No Yes

Have you ever had any fractures (including compression) of the spine?

- No Yes; what spinal level? _____

Do you have or have you had headaches early in the morning that sometime wake you up?

- No Yes; please explain: _____

Have you ever used: Immune-suppression: No Yes

Corticosteroids (Prednisone, Decadron, Medrol, etc.): No Yes

Blood thinners (Warfarin, Coumadin, Plavix, etc.): No Yes

Any abnormalities in recent blood and/or urine test? No Yes; explain: _____

Do you now or have you ever used recreational drugs or drugs intravenously?

- No Yes; please explain: _____

Are you sexually active? No Yes; do you practice safe sex? No Yes N/A

• **Men Only:** Last Physical Exam _____

• **Women Only:** Last menstrual period: _____

- Regular Pap smears: No Yes

- Regular Breast Exams: No Yes

I Don't Know the medical history of my biological parents or other family members. (skip this section)

Mother:	Father:	Siblings: <input type="checkbox"/> N/A	Children: <input type="checkbox"/> N/A
<input type="checkbox"/> Alive	<input type="checkbox"/> Alive	# of living brothers/sisters _____	# of Children: _____
<input type="checkbox"/> Deceased at age: ____	<input type="checkbox"/> Deceased at age: ____	# of deceased brothers/sisters _____	# of deceased children: _____
Cause: _____	Cause: _____		Causes: _____
History of major illness?	History of major illness?		

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5. Review Of Systems

General-

- Unexplained Weight loss or gain
- Fatigue
- Fever or Chills
- Nausea or Vomiting
- Night Sweats

Skin-

- Rashes
- Lumps
- Itching
- Dryness
- Color changes
- Hair and nail changes

Head-

- Headache
- Head injury

Ears-

- Decreased hearing
- Ringing in ears (tinnitus)
- Earache
- Drainage

Eyes-

- Blurry Vision
- Double Vision
- Pain
- Redness
- Flashing lights
- Specks
- Glaucoma
- Cataracts

Nose-

- Stuffiness
- Discharge
- Itching
- Hay fever
- Nosebleeds
- Sinus pain

Throat-

- Bleeding
- Sore tongue
- Dry mouth
- Sore throat
- Hoarseness
- Thrush
- Non-healing sores

Neck-

- Lumps

- Swollen glands

- Neck Pain
- Neck Stiffness

Breasts-

- Lumps
- Pain
- Discharge
- Self-exams
- Breast-feeding

Respiratory-

- Cough (dry or wet, productive)
- Sputum (color and amount)
- Coughing up blood
- Shortness of breath (dyspnea)
- Wheezing
- Painful breathing

Cardiovascular-

- Chest pain or discomfort
- Tightness
- Palpitations
- Shortness of breath with activity (dyspnea)
- Difficulty breathing lying down (orthopnea)
- Swelling (edema)
- Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)

Gastrointestinal-

- Swallowing difficulties
- Heartburn
- Change in appetite
- Change in bowel habits
- Rectal bleeding
- Constipation
- Diarrhea
- Yellow eyes or skin

Urinary-

- Urinary Urgency
- Burning or pain
- Blood in urine
- Incontinence
- Change in urinary Strength

Genital-

Male-

- Pain with sex
- Hernia
- Penile discharge
- Sores
- Masses or pain
- Erectile dysfunction
- STD's

Female-

- Pain with sex
- Vaginal dryness
- Hot flashes
- Vaginal discharge
- Itching or rash
- STD's

Vascular-

- Calf pain with walking (Claudication)
- Leg cramping

Musculoskeletal-

- Muscle pain
- Joint pain
- Stiffness
- Redness of joints
- Swelling of joints
- Trauma

Neurologic-

- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremor

Hematologic-

- Ease of bruising

Endocrine-

- Head or cold intolerance
- Sweating
- Frequent urination (polyuria)
- Thirst (polydypsia)
- Change in appetite (polyphagia)

Psychiatric-

- Nervousness
- Depression

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6. INSURANCE

(We can make a copy of your insurance card instead of filling this part out.)

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

ID # _____ Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

ID # _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with:

and assign directly to Dr. _____

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

How did you hear about us? TV Newspaper Referral Internet Other _____