☐ **Check this box if your symptoms are related to a workers comp or personal injury claim**

Patient's Name	Address	Phone	Date of Birth

Primary Care Physician Info			Referring Physician Info		
Name:			Name:		
Telephone:	**Fax:**		Telephone:	**Fax:**	
Address:			Address:		
City:	State:	Zip Code:	City:	State:	Zip Code:

History of Present Illness:

Physician Notes

What is the reason for your visit? Headache / Back pain / Neck pain / Arm pain / Leg pain
Right side / left side / both sides (circle one) Others:……………………………………

When did this problem start?

How would you best describe the pain? *Check all that apply.*

☐ Sharp ☐ Burning Sensation ☐ Numbness
☐ Dull ☐ Shooting pain ☐ ________________________

Please rate your pain by checking the number that best correlates to your pain level.

No Pain ***Least Pain*** ***Moderate Pain*** ***Most Severe Pain***
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What makes it worse?

☐ Nothing makes the symptoms worse ☐ Movement of any kind ☐ Sitting
☐ Standing ☐ Walking ☐ Lifting
☐ ____________________________ ☐ __________________ ☐ _______________

What helps?

☐ Nothing helps the symptoms ☐ Steroid injections ☐ Sitting
☐ Standing ☐ Walking ☐ Laying still
☐ Pain medication ☐ Physical therapy ☐ _______________

Is it worse at certain times of the day or night?

☐ Day ☐ Night ☐ Neither

Do you have any other related symptoms?

☐ Bowel incontinence ☐ Urine incontinence
☐ Weakness of arms or legs (please specify) ___________________________________

What treatments have been attempted in the past to alleviate your symptoms?

☐ Physical Therapy ☐ Steroid Injections ☐ Prior Surgery
☐ Occupational Therapy ☐ Pain management ☐ ___________________

Please check only those items, which apply to your personal medical history. (PMH)

☐ High Blood Pressure ☐ Cancer ☐ Lung problems / Asthma
☐ Diabetes ☐ High Cholesterol ☐ Headache
☐ Peptic Ulcers ☐ Hepatitis ☐ Accidents /broken bones
☐ Heart attack ☐ HIV ☐ Back pain
☐ Chest pain/Tightness ☐ Stroke ☐ Neck Pain
☐ Stroke ☐ Seizure ☐ Other ________________
☐ Other _____________

Patient Signature: ____ **Date:** ____________________

Previous Hospitalizations/Surgeries: (not including pregnancy)

Illness/Surgery	Date	Surgery	Date

Current Medications: (including vitamins and over the counter medications)

Medication	Dosage	Frequency	Reason for taking medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please Lists All Allergies:

☐ No known drug allergies	☐ Penicillin	☐ Iodine	☐ Contrast Dye
☐	☐	☐	☐

Please check if you are experiencing any of the following symptoms: (ROS)

☐ Chest pain	☐ Shortness of breath	☐ Seizures	☐ Urinary Incontinence	☐ Fever
☐ Palpitations	☐ Nausea	☐ Weakness	☐ Bowel Incontinence	☐ Swollen Legs
☐ Chest tightness	☐ Vomiting	☐ Headache	☐ Easy bruising	☐ Muscle Spasms
☐ Fainting Spells	☐ Dizziness	☐ Blurred Vision	☐ Easy Bleeding	☐ Neck Pain
☐ Heat Intolerance	☐ Depression	☐ Double Vision	☐ Difficulty Speaking	☐ Back pain
☐ Cold Intolerance	☐ Anxiety	☐ Loss of Vision	☐ Difficulty Swallowing	☐ Numbness

Social History: Check any of the following if they pertain to your current social situation.

Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ In a relationship

Employment:
☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired
Occupation: ________________________________

How many children do you have?
0-1-2-3-4-5-more ____

Tobacco Use:
Cigarettes ☐ Never ☐ Quit Date _________ ☐ Current smoker: packs/day _____ number of years _____
Other Tobacco ☐ Pipe ☐ Chew ☐ Cigar ☐ Snuff

Alcohol Use:
☐ Do you drink alcohol? ☐ Yes ☐ No Number of drinks per week __________

Drug Use:
Do you use any recreational drugs? ☐ Yes ☐ No Pain killer / Marijuana / Cocaine / others

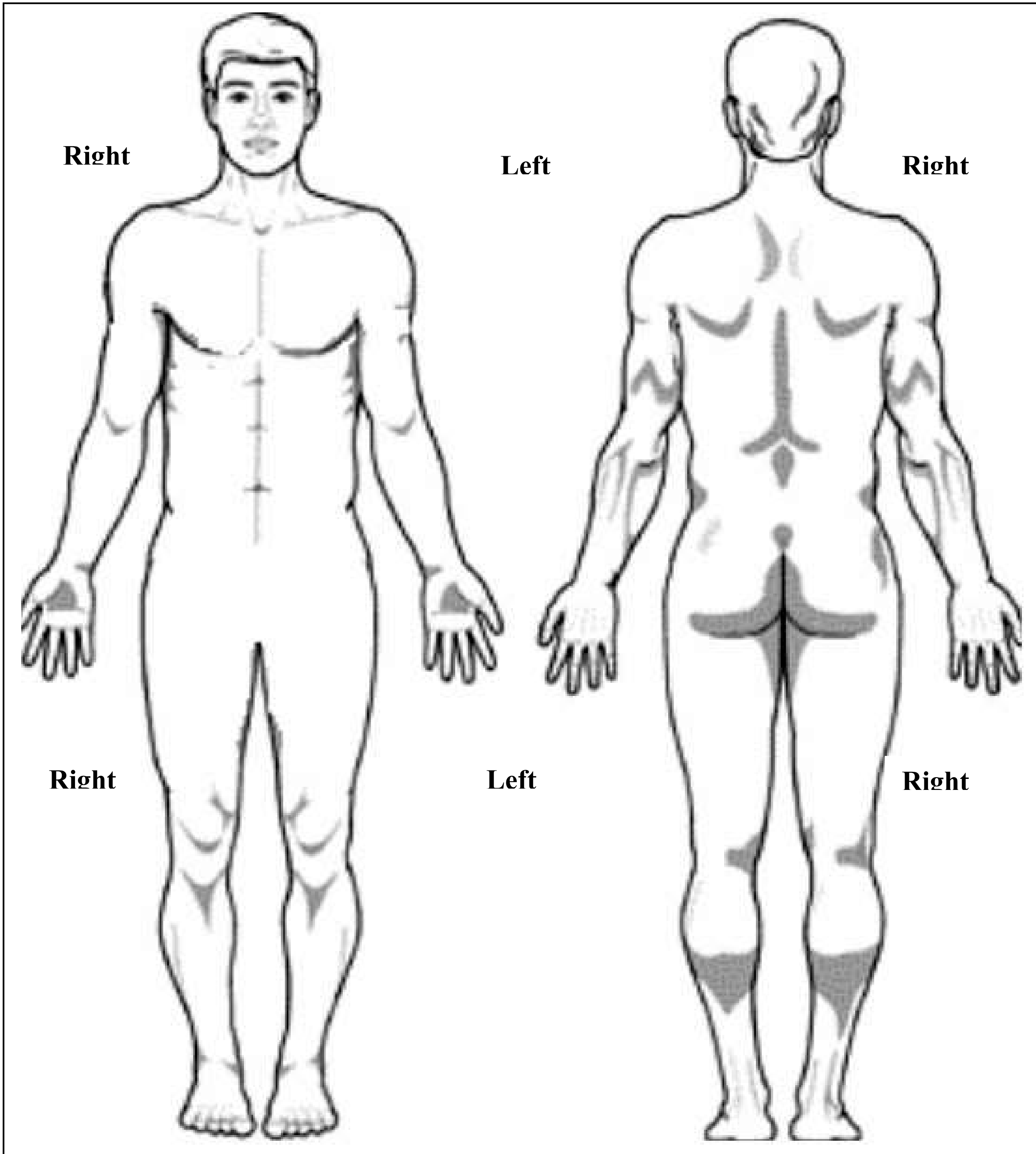
Family History: Check only the condition if a blood relative has suffered.

☐ Epilepsy	☐ Stroke	☐ Alcoholism	☐ Brain Tumors	☐ Osteoporosis
☐ Migraine	☐ Sickle Cell	☐ Bleeding Disorder	☐ Mental Illness	☐ Arthritis
☐ High Blood Pressure	☐ Cancer	☐ Multiple Sclerosis		

Patient Name ______________________ **DOB** ___________ **Date** _____________

Please use the following descriptive symbols on the body outlines below to describe the location of your symptoms.

Pain	Numbness	Pins & Needles	Burning	Weakness
XXXX	0000	……….	BBBB	+ + + +



Front **Back**

Patient Name: ____________________________ DOB:___________ **Date:** _______________