Name: _____ Age: _____ Date: _____

Primary Care Physician: _____ Referring Physician: _____ Phone #: _____

Was this injury due to an auto accident? Yes _____ No _____ Date of Injury: _____ Did this occur at work: Yes ☐ No ☐

Disability and Litigation: 1. SSI/SSDI? Yes ☐ No ☐ 2. Workers Comp? Yes ☐ No ☐ 3. Have you retained a lawyer? Yes ☐ No ☐

Is there a lawsuit involved? Yes _____ No _____ Right Handed ☐ Left Handed ☐

Chief Complaint: _____

Describe activities which aggravate or worsen your symptoms/pain: _____

Describe activities which decrease your symptoms/pain: _____

PAST MEDICAL HISTORY

	No	Yes	(please specify)
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Lung Disease	☐	☐	
Diabetes	☐	☐	
GI	☐	☐	
Kidney Disease	☐	☐	
Anemia/Blood Disease	☐	☐	
Cancer	☐	☐	
Depression	☐	☐	
Arthritis	☐	☐	
Osteoporosis	☐	☐	
Back/Neck	☐	☐	

Other (Please specify) _____

What treatments have you received?

- ☐ NSAID's (☐ Naproxen, ☐ Motrin, ☐ Aspirin, ☐ Celebrex)
- ☐ Oral/Injected Steroids ☐ Epidural Injection - Date _____
- ☐ Brace
- ☐ Pain Medications (☐ Neurontin, ☐ Lyrica, ☐ Ultram)
- ☐ Acupuncture/Chiropactor
- ☐ TENS/Ultrasound
- ☐ Narcotics (☐ Hydrocodone, ☐ Percocet, ☐ Oxycontin, ☐ Morphine)
- ☐ Physical Therapy
- ☐ Other _____

Do medications help? ☐ No ☐ Somewhat (1/3 better) ☐ Moderately (1/3 - 2/3 better) ☐ Greatly (>2/3 better)

Has anyone in your family, excluding your spouse, had these problems? - Mark ONLY if YES	Yes
No details known?	
AIDS/HIV?	
Alcohol abuse?	
Alzheimer's/Memory loss?	
Anemia?	
Arthritis?	
Asthma?	
Colon cancer?	
Lung cancer?	
Breast cancer?	
Cervical cancer?	
Prostate cancer?	
Depression?	
Diabetes?	
Drug abuse?	
Gout?	
Heart disease?	
Hypertension?	
Kidney disease?	
Liver disease?	
Muscle disease?	
Osteoporosis?	
Seizures?	
Stomach ulcers?	
Stroke?	
Other problems?	

Test taken for your current problem?	Yes	Date
X-ray?		
MRI?		
CT scan?		
Bone scan?		
EMG/NCS?		
Bone density test?		
Ultrasound or Doppler?		
Blood or other lab test?		
Other		

Females	No	Yes
Are your menstrual cycles regular?	☐	☐
Menopause?	☐	☐
Previous Pregnancies:		_____
Currently Pregnant?	☐	☐

SURGERIES

	No	Yes	Date	Describe
Heart	☐	☐	___/___/___	
Lung	☐	☐	___/___/___	
Adbominal	☐	☐	___/___/___	
Neck	☐	☐	___/___/___	
Back	☐	☐	___/___/___	
Orthopaedic	☐	☐	___/___/___	
Other	☐	☐	___/___/___	

continued on back

SOCIAL HISTORY

1. Occupation _____
2. Hours/week ☐ More than 40 ☐ 20-40 ☐ Less than 20 ☐ None
3. Type of work ☐ Heavy Labor ☐ Labor with restrictions ☐ Mostly sitting ☐ Sedentary
4. Have you changed your job or activity level because of your spine problem? ☐ Yes ☐ No
5. Currently how often do you execise? ☐ Everyday ☐ Every few days ☐ Less than once/week
6. Education ☐ High school ☐ College ☐ Graduate school
7. Smoking ☐ Never smoked ☐ Quit more than six months ago
8. Alcohol ☐ None ☐ Less than 10 per week ☐ More than 10 per week
9. Married ☐ Yes ☐ No
10. Children ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than 5

REVIEW OF SYSTEMS

GENERAL	No	Yes	DETAILS
Fever			
Chills			
Night sweats			
Weight loss			

SKIN	No	Yes	DETAILS
Rash			
Sores			

NEUROLOGY	No	Yes	DETAILS
Headache			
Black Outs			
Balance Difficulties			
Seizure			

EYES/EARS	No	Yes	DETAILS
Visual Problems			
Double Vision			
Hearing Difficulties			

NOSE/THROAT	No	Yes	DETAILS
Discharge			
Pain			
Soreness			
Swelling			
Sinusitis			

CARDIAC	No	Yes	DETAILS
Chest Pain			
Shortness of Breath			
Difficulty Breathing			

CHEST	No	Yes	DETAILS
Cough			
Asthma			
Bronchitis			

GI	No	Yes	DETAILS
Abdominal Pain			
Ulcer			
Bleeding			
Indigestion			
Constipation			

URINARY	No	Yes	DETAILS
Stones			
Infection			
Frequent Urination			
Incontinence			

REPRODUCTIVE	No	Yes	DETAILS
Discharge			
Infection			
Sores			
Sexual Problems			

MUSCULOSKELETAL	No	Yes	DETAILS
Arthritis			
Swelling			
Pain			
Fracture			
Weakness			

HEMATOLOGIC	No	Yes	DETAILS
Anemia			
Bleeding Disorders			
Clots			

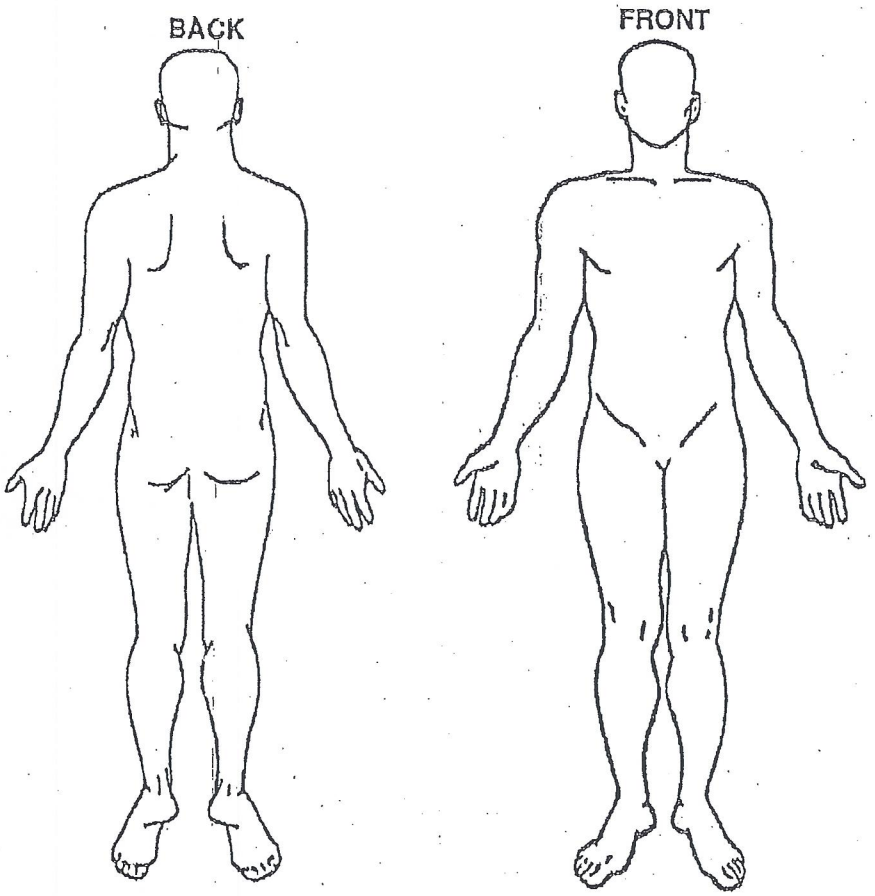
PSYCHIATRIC	No	Yes	DETAILS
Depression			
Bipolar			
Mood Swings			

Name: _____ Date: _____

Pain Diagram

Mark the areas on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Tingling 0000
Pain XXXX
Numbness IIII



Put a mark through the line below to rate your pain intensity on average
No pain ---------- worst possible pain

Put a mark through the line below to rate your pain intensity at its worst
No pain ---------- worst possible pain