

Patient's Legal Name \_\_\_\_\_  
 Last First Middle

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male  Female  Occupation \_\_\_\_\_

Referred by \_\_\_\_\_ Family Physician \_\_\_\_\_

**PLEASE COMPLETE ALL AREAS INSIDE THIS BOX:**

1) Was this an accident:  Yes If an accident what Date: \_\_\_\_\_  No (if no, go to #3)

2) If an accident, please explain how it happened: \_\_\_\_\_  
 \_\_\_\_\_

3) If not an accident, when was the onset of today's condition: \_\_\_\_\_  
 \_\_\_\_\_

4) Specific location of injury or pain: Right \_\_\_\_\_ Left \_\_\_\_\_ Location \_\_\_\_\_

5) Is pain sharp / dull, constant / occasional? \_\_\_\_\_

6) What are your symptoms? \_\_\_\_\_  
 \_\_\_\_\_

7) On a scale of 1 to 10, 10 being the worst, what is the severity of your pain? \_\_\_\_\_

8) What activities make the problem feel worse? \_\_\_\_\_  
 or better? \_\_\_\_\_

9) How long have you experienced this problem? \_\_\_\_\_

10) If you have had an X-ray, MRI, PT or Injections in the last 60 days for this problem, please list those here: \_\_\_\_\_  
 \_\_\_\_\_

List all medications that you are currently taking (prescription and non-prescription):  See attached medication list

Medication Name	Dosage	Times/Day	Medication Name	Dosage	Times/Day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS?:  Yes  No Latex Allergy?:  Yes  No

List any medications that you are allergic to and the reaction it causes:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PRIMARY PHARMACY \_\_\_\_\_ PHONE NO. \_\_\_\_\_

ARE YOU OR HAVE YOU BEEN UNDER CARE OF A PAIN CLINIC?  Yes  No

DO YOU HAVE A HISTORY OF BLOOD CLOTS OR DVT?  Yes  No

Prior Surgeries: \_\_\_\_\_  
 \_\_\_\_\_

**ROS** Please check all CURRENT positive findings that apply to you or mark none.

<b>CONSTITUTIONAL</b>	<input type="checkbox"/> weight loss	<input type="checkbox"/> weight gain	<input type="checkbox"/> loss of appetite	<input type="checkbox"/> weakness	<input type="checkbox"/> NONE
<b>EENT</b>	<input type="checkbox"/> blurry vision	<input type="checkbox"/> hoarseness	<input type="checkbox"/> ringing in ears		<input type="checkbox"/> NONE
<b>CARDIAC</b>	<input type="checkbox"/> chest pain	<input type="checkbox"/> irregular heartbeat	<input type="checkbox"/> swelling in the legs or feet		<input type="checkbox"/> NONE
<b>RESPIRATORY</b>	<input type="checkbox"/> pain when breathing	<input type="checkbox"/> shortness of breath			<input type="checkbox"/> NONE
<b>GASTROINTESTINAL</b>	<input type="checkbox"/> liver problems	<input type="checkbox"/> blood in stool	<input type="checkbox"/> gallbladder problems		<input type="checkbox"/> NONE
<b>GENITOURINARY</b>	<input type="checkbox"/> bladder problems	<input type="checkbox"/> incontinence	<input type="checkbox"/> pain with urination	<input type="checkbox"/> kidney stones	<input type="checkbox"/> NONE
<b>INTEGUMENTARY</b>	<input type="checkbox"/> rashes	<input type="checkbox"/> skin ulcers	<input type="checkbox"/> changes in skin		<input type="checkbox"/> NONE
<b>NEUROLOGICAL</b>	<input type="checkbox"/> headaches	<input type="checkbox"/> numbness/tingling	<input type="checkbox"/> seizures	<input type="checkbox"/> dizziness <input type="checkbox"/> faintness	<input type="checkbox"/> NONE
<b>MENTAL HEALTH</b>	<input type="checkbox"/> depression	<input type="checkbox"/> sleep disorder	<input type="checkbox"/> nervousness	<input type="checkbox"/> fainting spells	<input type="checkbox"/> NONE
<b>HEMATOLOGIC</b>	<input type="checkbox"/> easy bleeding	<input type="checkbox"/> easy bruising	<input type="checkbox"/> bleeding problems		<input type="checkbox"/> NONE
<b>ENDOCRINE</b>	<input type="checkbox"/> thyroid problems	<input type="checkbox"/> low blood pressure	<input type="checkbox"/> thirst		<input type="checkbox"/> NONE
<b>MUSCULOSKELETAL</b>	<input type="checkbox"/> joint pain	<input type="checkbox"/> muscle pain	<input type="checkbox"/> cramps	<input type="checkbox"/> limitation in motor activity	<input type="checkbox"/> NONE

**HISTORY** Please check all that apply (Family refers to parents, brothers, sisters, or children)

Condition	You	Family	Condition	You	Family	Condition	You	Family
Jaundice or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Type _____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>			

Have you ever been diagnosed/treated for any other conditions/illness not listed above \_\_\_\_\_

Women: Are you pregnant? Yes  No  Date of last menstrual period: \_\_\_\_\_

**SOCIAL HISTORY:**

Do you smoke? Yes  No  # of Years \_\_\_\_\_ Packs per day \_\_\_\_\_

Do you drink alcoholic beverages? Yes  No  Drinks per week \_\_\_\_\_

Marital Status: Married  Single  Divorced  Widowed  Number of Children \_\_\_\_\_

Occupation: \_\_\_\_\_ Currently Working: Yes  No

<i>I hereby certify by my signature that the medical information given on this form is correct to the best of my knowledge.</i>	
Patient Signature _____	Date _____
<b>DO NOT SIGN BELOW UNLESS ASKED TO UPDATE YOUR FORM DURING A RETURN VISIT</b>	
<i>I hereby certify that I have reviewed and updated the medical information on this form and it is currently accurate.</i>	
Patient Signature - Update # 1 _____	Date _____ Physician Signature - Update # 1 _____ Date _____
Patient Signature - Update # 2 _____	Date _____ Physician Signature - Update # 2 _____ Date _____
Patient Signature - Update # 3 _____	Date _____ Physician Signature - Update # 3 _____ Date _____

**PHYSICAL EXAMINATION:** Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Vital Signs:** B/P \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ T \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ R or L Hand Dominant \_\_\_\_\_

	Within Normal Limits		Findings
	Yes	No	
HENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Data _____			

**IMPRESSION/DIAGNOSIS:** \_\_\_\_\_

**PLAN:** \_\_\_\_\_

The patient has been advised of the plan and/or procedure, including the potential risks and benefits, and agrees to proceed.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_