



Today's Date: \_\_\_\_\_

Patient's Legal Name: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

1. Specific location of injury or pain: \_\_\_\_\_ Right \_\_\_\_\_ Left Body Part: \_\_\_\_\_

2. Was this an accident? \_\_\_\_\_ Yes \_\_\_\_\_ No (If "No", skip to #5)

3. If an accident, please explain how it happened:  
\_\_\_\_\_

4. What was the date of the accident? \_\_\_\_/\_\_\_\_/\_\_\_\_ Where did it occur? \_\_\_\_\_

5. If not an accident, how long have you experienced this problem? \_\_\_\_\_

6. Describe the quality of your pain (ex: Sharp, Dull, Constant, Occasional) \_\_\_\_\_

7. What are your symptoms? \_\_\_\_\_

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

9. What activities make the problem feel worse? \_\_\_\_\_

10. What makes the problem feel better? \_\_\_\_\_

11. What tests/procedures you have had in the last 60 days for this problem? (ex: xray, MRI, CT, injection)  
\_\_\_\_\_

12. Where was the test done? \_\_\_\_\_

**MEDICAL HISTORY:** If you have any of the following, PLEASE FILL IN THE OVAL COMPLETELY:

- |  |  |   |  |
|--|--|---|--|
| <input type="radio"/> ADD/ADHD           | <input type="radio"/> Cancer : Colon       | <input type="radio"/> Heart Disease             | <input type="radio"/> Rheumatoid Arthritis |
| <input type="radio"/> AIDS/HIV           | <input type="radio"/> Cancer : Lung        | <input type="radio"/> Hepatitis / Jaundice      | <input type="radio"/> Scoliosis            |
| <input type="radio"/> Alzheimer's        | <input type="radio"/> Cancer : Prostate    | <input type="radio"/> High Blood Pressure       | <input type="radio"/> Seizures             |
| <input type="radio"/> Anemia             | <input type="radio"/> Colitis / Crohn's    | <input type="radio"/> Implantable Defibrillator | <input type="radio"/> Sleep Apnea          |
| <input type="radio"/> Asthma             | <input type="radio"/> COPD / Emphysema     | <input type="radio"/> Kidney Disease            | <input type="radio"/> Stomach Ulcers       |
| <input type="radio"/> Blood Clot/DVT Leg | <input type="radio"/> Depression / Anxiety | <input type="radio"/> Lupus                     | <input type="radio"/> Stroke               |
| <input type="radio"/> Blood Clot/Lung    | <input type="radio"/> Diabetes             | <input type="radio"/> Pacemaker                 | <input type="radio"/> NONE                 |
| <input type="radio"/> Cancer : Breast    | <input type="radio"/> Drug Abuse           | <input type="radio"/> Psoriasis                 |  |

OTHER:  
\_\_\_\_\_

Have you, or have you ever been under the care of a pain clinic?  Yes  No

Have you received the FLU Vaccine within the past year?  Yes  No

Have you received the PNEUMONIA Vaccine within the past year?  Yes  No

Preferred Pharmacy: \_\_\_\_\_ Phone No: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Patient's Legal Name: \_\_\_\_\_



**SURGICAL HISTORY:** If you have any of the following, PLEASE FILL IN THE OVAL COMPLETELY. Also, please list the year.

- |  |   |  |  |
|--|---|--|--|
| <input type="radio"/> Appendectomy           | <input type="radio"/> Cardiac Stent         | <input type="radio"/> Heart Surgery    | <input type="radio"/> Mastectomy         |
| <input type="radio"/> Arthroscopy : Shoulder | <input type="radio"/> Carpal Tunnel Release | <input type="radio"/> Hip Replacement  | <input type="radio"/> Spinal Surgery     |
| <input type="radio"/> Arthroscopy : Knee     | <input type="radio"/> Gallbladder           | <input type="radio"/> Hysterectomy     | <input type="radio"/> Stomach Procedure  |
| <input type="radio"/> Bunionectomy           | <input type="radio"/> Gastric Bypass        | <input type="radio"/> Knee Replacement | <input type="radio"/> Vascular Procedure |

**OTHER:**

Have you ever received General Anesthesia?  Yes  No

If Yes, did you have any problems with the Anesthesia?  Yes  No

If Yes, please explain: \_\_\_\_\_

**MEDICATIONS:** If you take any of the following medications, PLEASE FILL IN THE OVAL COMPLETELY.

- |  |   |   |
|--|---|---|
| <input type="radio"/> Adderall (Dextroamphetamine)   | <input type="radio"/> Lasix (Furosemide)            | <input type="radio"/> Skelaxin (Metaxalone)     |
| <input type="radio"/> Ambien (Zolpidem)              | <input type="radio"/> Lexapro (Escitalopram)        | <input type="radio"/> Synthroid (Levothyroxine) |
| <input type="radio"/> Buspar (Buspirone)             | <input type="radio"/> Lipitor (Atrovastatin)        | <input type="radio"/> Tenormin (Atenolol)       |
| <input type="radio"/> Celebrex (Celecoxib)           | <input type="radio"/> Lopressor (Metoprolol)        | <input type="radio"/> Ultram (Tramadol)         |
| <input type="radio"/> Celexa (Citalopram)            | <input type="radio"/> Lyrica (Pregabalin)           | <input type="radio"/> Tylenol (Acetaminophen)   |
| <input type="radio"/> Coumadin (Warfarin)            | <input type="radio"/> Mobic (Meloxicam)             | <input type="radio"/> Valium (Diazepam)         |
| <input type="radio"/> Cozaar (Losartan)              | <input type="radio"/> Neurontin (Gabapentin)        | <input type="radio"/> Xanax (Alprazolam)        |
| <input type="radio"/> Cymbalta (Duloxetine)          | <input type="radio"/> Nexium (Esomeprazole)         | <input type="radio"/> Zocor (Simvastatin)       |
| <input type="radio"/> Dilantin (Phenytoin)           | <input type="radio"/> Norco/Lortab/Vicodin/Lorcet   | <input type="radio"/> Zyrtec (Cetirizine)       |
| <input type="radio"/> Dolophine/Metadose (Methadone) | <input type="radio"/> Norvasc (Amlodipine)          | <b>NSAIDS (select below)</b>                    |
| <input type="radio"/> Insulin (Name: _____)          | <input type="radio"/> Percocet                      | <input type="radio"/> Naprosyn/Aleve (Naproxen) |
| <input type="radio"/> Flexeril (Cyclobenzaprine)     | <input type="radio"/> Plavix (Clopidogrel)          | <input type="radio"/> Motrin/Advil (Ibuprofen)  |
| <input type="radio"/> Flomax (Tamsulosin)            | <input type="radio"/> Pravachol (Pravastatin)       | <b>Vitamin Supplements (list)</b>               |
| <input type="radio"/> Glucophage (Metformin)         | <input type="radio"/> Prinivil/Zestril (Lisinopril) | _____   |
| <input type="radio"/> HCTZ (Hydrochlorothiazide)     | <input type="radio"/> Prozac (Fluoxetine)           |   |
| <input type="radio"/> Klonopin (Clonazepam)          | <input type="radio"/> Robaxin (Methocarbamol)       | <input type="radio"/> <b>NONE</b>               |

**OTHER:**

**ALLERGIES:** If you have allergies to any of the following, PLEASE FILL IN THE OVAL COMPLETELY.

- |  |  |   |  |
|--|--|---|--|
| <input type="radio"/> Amoxicillin  | <input type="radio"/> Hydrocodone      | <input type="radio"/> <b>Latex</b>        | <input type="radio"/> Sulfa Drugs        |
| <input type="radio"/> Ampicillin   | <input type="radio"/> Insulin          | <input type="radio"/> <b>Nickel/Metal</b> | <input type="radio"/> Tape/Adhesive      |
| <input type="radio"/> Bactrim / Septra                                   | <input type="radio"/> Iodine/Shellfish | <input type="radio"/> Penicillin          | <input type="radio"/> Seasonal Allergies |
| <input type="radio"/> Cephalosporins (Ceftin / Cefzil / Keflex / Suprax) | <input type="radio"/> Keflex           | <input type="radio"/> Septra              | <input type="radio"/> <b>NONE</b>        |
| <input type="radio"/> Codeines   |  |   |  |

**OTHER:**

Today's Date: \_\_\_\_\_

Patient's Legal Name: \_\_\_\_\_



**SOCIAL HISTORY:** PLEASE FILL IN THE OVAL COMPLETELY to answer the following questions.

**Do You Currently Use Tobacco?**  Yes  No **Approximate AGE when you started?** \_\_\_\_\_

**If YES, what type do you use?**  Smoking  Smokeless Vapor  Chewing

**Packs Per Day?**  1  2  3  4 >

**Please Select a Smoking Status:**

- |   |  |  |
|---|--|--|
| <input type="radio"/> NEVER smoker            | <input type="radio"/> CURRENT Sometimes Smoker | <input type="radio"/> Current Status Unknown |
| <input type="radio"/> FORMER smoker           | <input type="radio"/> LIGHT Tobacco User       | <input type="radio"/> Unknown if Ever Smoked |
| <input type="radio"/> CURRENT Everyday Smoker | <input type="radio"/> HEAVY Tobacco User       |  |

**Do you use Alcohol?**  Yes  No **Drinks per Day?**  1-3  4-6  7+  Occasional

**Marital Status?**  Single  Married  Divorced  Widowed

**Number of Children?**  1  2  3  4  5 >

**Hand Dominance?**  Right  Left  Ambidextrous

**Currently Working?**  Yes  No **OCCUPATION:** \_\_\_\_\_

**FEMALES ONLY: Could you be pregnant?**  Yes  No **Last Menstrual Cycle?** \_\_\_\_\_

**FAMILY HISTORY:** PLEASE FILL IN THE OVAL COMPLETELY if you have a family member with the following:

Unknown / Adopted

	Father	Mother	Brother	Sister	Son	Daughter	Other
AIDS/ HIV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood Clots	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer (Breast)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer (Colon)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer (Lung)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer (Prostate)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coronary Artery Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gout	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hemophilia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoarthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Today's Date: \_\_\_\_\_



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**REVIEW OF SYSTEMS:** If you have any of the following PLEASE FILL IN THE OVAL COMPLETELY.

Please make a selection for EACH BOX.

**CONSTITUTIONAL**

Weight Loss / Gain

Weakness

Loss of Appetite

NONE

**ENDOCRINE**

Thyroid Trouble

Low Blood Pressure

Excessive Thirst

NONE

**CARDIOVASCULAR**

Chest Pain

Irregular Heart Beat

Swelling of Legs / Feet

NONE

**GASTROINTESTINAL**

Rectal Bleeding

Gallbladder Trouble

Liver Problems

NONE

**HEMATOLOGICAL**

Bleeding Problems

Easy Bleeding

Easy Bruising

NONE

**EENT**

Blurred Vision

Hoarseness

Ears Ringing

NONE

**INTEGUMENTARY**

Rashes

Skin Ulcers

Changes in Skin

NONE

**RESPIRATORY**

Shortness of Breath

Pain when Breathing

NONE

**GENITOURINARY**

Bladder Problems

Incontinence

Kidney Stones

Burning Urination

NONE

**MUSCULOSKELETAL**

Joint Pain

Cramps

Limitation in Activity

Muscle Pain

NONE

**MENTAL HEALTH**

Nervousness

Depression

Sleep Disorder

Fainting Spells

NONE

**NEUROLOGICAL**

Headache

Dizziness

Seizures

Numbness / Tingling

Faintness

NONE

*I hereby certify by my signature that the medical information given on this form is correct to the best of my knowledge.*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**FOR PHYSICIAN USE ONLY:**

**PHYSICAL EXAMINATION** Vitals Signs B/P \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ T \_\_\_\_\_

	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/Time \_\_\_\_\_