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:

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

○ Appendectomy	○ Cardiac Stent	○ Heart Surgery	○ Mastectomy
○ Arthroscopy : Shoulder	○ Carpal Tunnel Release	○ Hip Replacement	○ Spinal Surgery
○ Arthroscopy : Knee	○ Gallbladder	○ Hysterectomy	○ Stomach Procedure
○ Bunionectomy	○ Gastric Bypass	○ Knee Replacement	○ Vascular Procedure

○ OTHER:

Have you ever received General Anesthesia ? ○ Yes ○ No

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

If Yes, please explain:_____

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

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

○ OTHER:

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

○ Amoxicillin	○ Hydrocodone	○ **Latex**	○ Sulfa Drugs
○ Ampicillin	○ Insulin	○ **Nickel/Metal**	○ Tape/Adhesive
○ Bactrim / Septra	○ Iodine/Shellfish	○ Penicillin	○ Seasonal Allergies
○ Cephalosporins (Ceftin/ Cefzil / Keflex /Suprax)	○ Keflex	○ Septra	○ **None**
○ Codeines			

○ OTHER:

Today's Date:_____

Patient's Legal Name:_____

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SOCIAL HISTORY: PLEASE FILL IN TH EOVAL 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?

- ○ NEVER Smoker
- ○ FORMER Smoker
- ○ CURRENT Everyday Smoker
- ○ CURRENT Sometimes Smoker
- ○ LIGHT Tobacco User
- ○ HEAVY Tobacco User
- ○ Current Status Unknown
- ○ Unknown if Ever Smoked

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 ○ Ambidextrious

Currently Working? ○ Yes ○ No OCCUPATION:_____

FEMALES ONLY: Could you be pregnant? ○ Yes ○ No **Last Menstural 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	○	○	○	○	○	○	○
Anemia	○	○	○	○	○	○	○
Blood Clots	○	○	○	○	○	○	○
Cancer (Breast)	○	○	○	○	○	○	○
Cancer (Colon)	○	○	○	○	○	○	○
Cancer (Lung)	○	○	○	○	○	○	○
Cancer (Prostate)	○	○	○	○	○	○	○
Coronary Artery Disease	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○
Gout	○	○	○	○	○	○	○
Heart Attack	○	○	○	○	○	○	○
Hemophilia	○	○	○	○	○	○	○
Hypertension	○	○	○	○	○	○	○
Kidney Disease	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○
Muscle Disease	○	○	○	○	○	○	○
Osteoarthritis	○	○	○	○	○	○	○
Osteoporosis	○	○	○	○	○	○	○
Rheumatoid Arthritis	○	○	○	○	○	○	○

Today's Date:_____

Patient's Legal Name:_____

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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: **Vital Signs** **B/P** _____ **P** _____ **R** _____ **T** _____

	Within Normal Limits? YES	NO	Findings
HENT	□	□	_____
Eyes	□	□	_____
Neck	□	□	_____
Heart	□	□	_____
Lungs	□	□	_____
Abdomen	□	□	_____
Neurological	□	□	_____
Musculoskeletal	□	□	_____
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**_____