

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Primary Care Provider: _____ Who Referred: _____

If not referred, how did you choose this office? _____

Why are you seeing the doctor today? _____

Please list major complaint(s) and describe their onset (i.e., lower back pain began in May 2012 after lifting):

Are you having any? Numbness Weakness Loss of bowel or bladder control

Where? _____
Where? _____

What makes your symptoms better (please circle all that apply): Nothing, rest, changing position, standing, sitting, walking, running, kneeling, bending, twisting.

What worsens your symptoms (please circle all that apply): Nothing, rest, changing position, standing, sitting, walking, running, kneeling, bending, twisting.

Is this visit related to an injury? Yes No On the job? Yes No

If so, date of injury: _____ Date of last employment: _____

Do you have any open worker's compensation claims of any kind? Yes No

Do you have a lawsuit pending? Yes No

Please circle the description which applies to your intensity of pain: Stable, unchanged, gradually worsening, rapidly worsening, gradually improving, rapidly improving, completely resolved.

How long has the problem been present? _____ Day(s), _____ Week(s), _____ Month(s), _____ Year(s)

What started the pain/problem? _____

Quality of the pain (mark up to four): Sharp Shooting Crushing Tight Band
 Numbing Pulsating Aching
 Tingling Dull Throbbing

How severe is the pain at the location described above? No Pain Mild Moderate Severe

Is the pain (check all that apply)? Rare Infrequent Occasional Intermittent
 Daily Continuous Weekly Monthly

What treatments have you tried for this problem?

- Physical Therapy
- Massage
- Chiropractor
- Other: _____
- TENS units
- Traction
- Surgery
- Narcotic Medications
- Anti-inflammatories
- Steroid injections
- Muscle Relaxers
- Orthotics
- Braces

Previous physicians seen for this problem?

Physician	Specialty	City	Treatment

PAST MEDICAL HISTORY: Check all that apply None Apply

- Abnormal heartbeat
- ADHD
- Anemia
- Anxiety
- Asthma
- Bleeding disorder
- Blood clots in leg
- Blood clots in lung
- Cerebral palsy
- Osteoarthritis
- Cirrhosis
- Depression
- Down syndrome
- Emphysema
- Gastric reflux
- Gout
- Heart attack
- Heart failure
- Hepatitis B or C
- Rheumatoid arthritis
- High blood pressure
- High cholesterol
- HIV/AIDS
- Kidney failure
- Kidney stones
- Migraine
- Multiple Sclerosis (MS)
- Neurofibromatosis
- Osteoporosis
- Other Rheumatological Disease
- Neuropathy: Hands
 Feet
- Poor circulation
- Seizure
- Spina bifida
- Stomach ulcers
- Stroke
- Thyroid
- Tuberculosis
- Fibromyalgia

Cancer: _____ (type/treatment)

Diabetes: If yes, when was it diagnosed? _____

Currently controlled with: insulin oral medications diet

Other : _____

PAST SURGICAL HISTORY:

No prior surgery

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia? Yes No

If yes, have you had any problems related to this? Yes No

Explain any problems with general anesthesia: _____

SOCIAL HISTORY: Work status

Working Homemaker Unemployed Disabled On leave Retired Student

Occupation: _____

Education: _____

Marital status: Single Married Divorced Widowed

Children: No Yes, how many? _____

Do you live alone? Yes No If no, who lives with you? _____

Are you currently smoking? Yes No If yes, how many pack/day? _____ And for how many years? _____

Have you previously quit smoking? If so, when did you quit? _____ How many years did you smoke? _____

How many packs a day did you previously smoke? _____ Other forms of tobacco used? _____

Alcohol use: Never Rare Social Frequently (more than twice a week)
 Alcoholic Recovering alcoholic

Illegal drug use: Never In the past Currently Types of drugs? _____

Sexually active: Yes No

FAMILY HISTORY: Please fill in the illness information below with the options listed:

- | | | | |
|-------------------|----------------|---------------------|-------------------------------|
| Alcoholism | Cancer | High blood pressure | Other Rheumatological Disease |
| Arthritis | Diabetes | Kidney problems | Seizure |
| Bleeding problems | Gout | Lung problems | Stroke |
| Blood clots | Heart problems | Mental Illness | |

Other: _____

FAMILY MEMBER	ILLNESS	AGE	IF DECEASED, AGE AT DEATH AND CAUSE
Father			
Mother			
Brother(s)			
Sisters			
Children			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Paternal Uncle			
Paternal Aunt			
Maternal Uncle			
Maternal Aunt			

Family History Unknown

Adopted

PAIN DIAGRAM

On the diagram below, please indicate where you are experiencing pain or other symptoms.

Use the following to describe your symptoms:

A = Ache

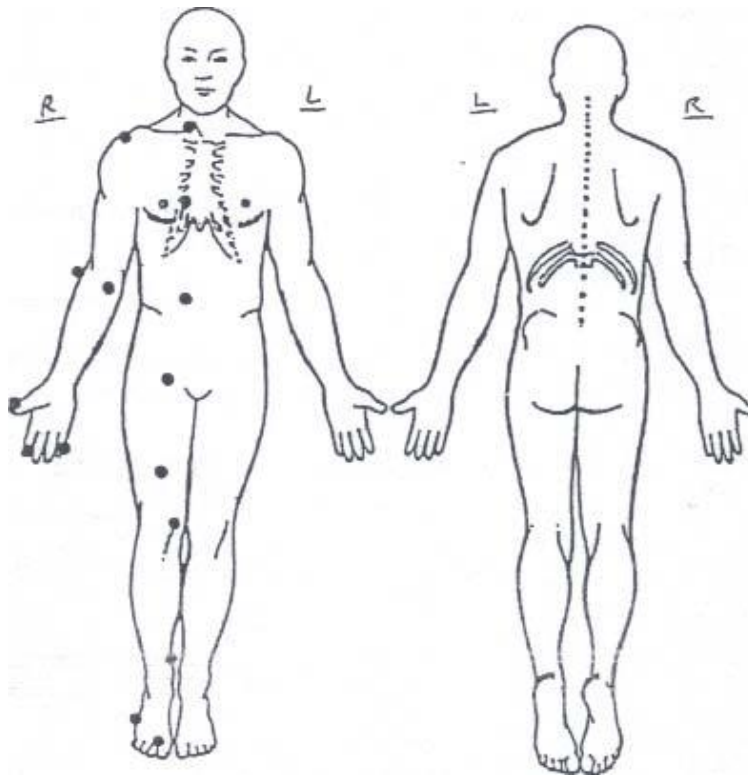
B = Burning

N = Numbness

P = Pins & Needles

S = Stabbing

O = Other



Please rate your usual level of pain on the following scale (circle one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Patient's signature: _____ Provider signature: _____

Date: _____ Date: _____