



1206D-2313

Patient Name: _____ Date of Birth: _____ Date: _____
 Age: _____ Gender: M F
 Occupation: _____
 Hand Dexterity: Right Left Ambidextrous

Please check the box that best applies to you (check only one box):

I am here today because I was referred by a physician for consultation.
 Physician Name: _____ Telephone: (____) _____
 Office Address: _____ Fax: (____) _____
 City: _____ State: _____ Zip: _____

OR

I am here today because I was self-referred patient for a second opinion.
 Please provide the name and address of any other physician to whom you would like us to send a report:
 Physician Name: _____ Telephone: (____) _____
 Office Address: _____ Fax: (____) _____
 City: _____ State: _____ Zip: _____

Chief Complaint (Check):

- Upper Mid Lower Back Legs Buttock Hip Ankle
 Right Left Both Neck Arms Wrist Hands Shoulder Elbow

Please describe your current symptoms and the duration (length of time) you have been experiencing them:

Surgical History (List all other surgeries you have had):

Year	Type of Surgery	Year	Type of Surgery

Complications (Check and explain any complications you have had after any of your surgeries):

Infection:	Pneumonia:
Bleeding:	Lung Problems:
Blood Clot:	Severe Nausea/Vomiting:
Anesthesia Reaction:	Other:

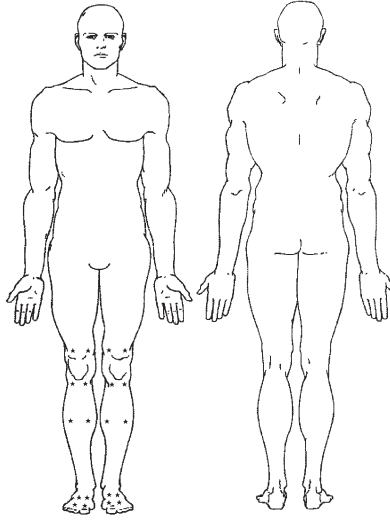
Mark the areas on your body where you feel the described sensations. Use the appropriate symbol to indicate all affected areas.

NUMBNESS -----

PINS & NEEDLES 000000

BURNING XXXXXX

STABBING /////



Motor Vehicle Accident?

Yes No

Date of Accident: _____

Work Related?

Yes No

Employer: _____

LEGAL Actions pending?

Yes No

Filed on what day: _____

Are you working now?

Yes No

Last Day Worked: _____

What is your **pain level** on a scale from 0 to 10 (0 = NO Pain, 10 = Worst Pain Imaginable)? _____

How far are you able to walk without your symptoms causing you to stop and rest?

Do you use any devices to help with walking?

Cane Walker Wheelchair Motorized Scooter

Aggravating Factors:

Lifting Coughing Sneezing Standing Walking Sitting Climbing Stairs

The pain is described as:

Constant Intermittent Unchanged Worse Better

Describe your pain:

Burning Sharp-shooting Tingling Numbness Pinprick Stabbing
 Deep-pressure Tightness Spasms

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Treatment & Evaluations: MRI X-Ray CT EMG Bone Scan Blood/Laboratory Epidurals

Have you tried any of the following treatments for pain?

TENS Heating Pad Ice Exercise Inversion Table Surgery Medications Acupuncture Chiropractor

Physical Therapy (PT) If yes, how many PT sessions have you had in the last year? _____. When was your last session? _____. Did the PT session help you? Yes No

Injections/Epidurals If yes, how many Injections/Epidurals have you had in the last year? _____. When was your last Injections/Epidurals? _____. Did the Injections/Epidurals help you? Yes No

What makes pain worse? _____

What makes pain better? _____

How does the pain limit you? _____

Bowel or bladder problems? No Yes: Be specific: _____

Have you had any problems with balance? No Yes

List all Medications you take regularly (include non-prescription meds): See Attached List

Name & Dose	How Often	Name & Dose	How Often

Have you taken any of the following medications in the past year?

Pain Medications Nerve Medications Steroid NSAIDs (i.e., ibuprofen, Celebrex, Naprosyn)

If you checked one or more boxes, were these medications effective for you? Yes No

Allergies: No Yes If yes, please list medication and reaction to it below:

Medication	Reaction	Medication	Reaction

Social History:

Do you drink alcohol? No Yes If yes, what is the average of drinks per week: _____

Do you smoke? No Yes If yes, how many packs/day: _____ For how long: _____

Previous history No Yes If yes, for how many years: _____

Do you use drugs recreationally? No Yes If yes, what substance and how frequently: _____

Review of Symptoms: (Check any recent/current problems, check symptoms or write in other):

N	Y	System	Symptoms/Problems	Other
		General/Constitutional	<input type="checkbox"/> Fever, <input type="checkbox"/> Unexplained Weight Loss/Gain, <input type="checkbox"/> Weakness, <input type="checkbox"/> Nausea, <input type="checkbox"/> Vomiting	
		Eyes/Vision	<input type="checkbox"/> Glasses/Contacts, <input type="checkbox"/> Blurred, <input type="checkbox"/> Double, <input type="checkbox"/> Dry Eyes, <input type="checkbox"/> Visual Loss, <input type="checkbox"/> Color Blindness, <input type="checkbox"/> Glaucoma	
		Ears, Nose, Throat, Mouth	<input type="checkbox"/> Vertigo, <input type="checkbox"/> Sinusitis, <input type="checkbox"/> Hoarseness, <input type="checkbox"/> Loss of Hearing, <input type="checkbox"/> Post Nasal Drip	
		Cardiovascular	<input type="checkbox"/> Chest Pain, <input type="checkbox"/> Murmurs, <input type="checkbox"/> Palpitations, <input type="checkbox"/> Irregular Rhythm, <input type="checkbox"/> Arrhythmia	
		Respiratory	<input type="checkbox"/> Short of Breath, <input type="checkbox"/> Asthma, <input type="checkbox"/> Cough, <input type="checkbox"/> Wheezing, <input type="checkbox"/> Pneumonia, <input type="checkbox"/> Tuberculosis	
		Digestive Tract	<input type="checkbox"/> Diarrhea, <input type="checkbox"/> Constipation, <input type="checkbox"/> Ulcers, <input type="checkbox"/> GERD, <input type="checkbox"/> Pain, <input type="checkbox"/> Appetite Change, <input type="checkbox"/> Jaundice, <input type="checkbox"/> Hemorrhoids, <input type="checkbox"/> Irritable Bowels	
		Kidney/Urinary	<input type="checkbox"/> Stones, <input type="checkbox"/> Burning, <input type="checkbox"/> Itching, <input type="checkbox"/> Blood in Urine, <input type="checkbox"/> Painful Urination, <input type="checkbox"/> Impotence	
		Skin/Breast	<input type="checkbox"/> Rash, Lump, <input type="checkbox"/> Itching, <input type="checkbox"/> Hair or Nails Change, <input type="checkbox"/> Easy Bruising/Bleeding	
		Endocrine	<input type="checkbox"/> Excess Thirst, <input type="checkbox"/> Decreased Energy, <input type="checkbox"/> Diabetes, <input type="checkbox"/> Abnormal Growth, <input type="checkbox"/> Goiter, <input type="checkbox"/> Heat/Cold Intolerance	
		Neurologic	<input type="checkbox"/> Balance, <input type="checkbox"/> Numbness/Tingling, <input type="checkbox"/> Seizure, <input type="checkbox"/> Tremor, <input type="checkbox"/> Headaches, <input type="checkbox"/> Paralysis	
		Psychiatric	<input type="checkbox"/> Depressions, <input type="checkbox"/> Anxiety, <input type="checkbox"/> Sleep Disorder, <input type="checkbox"/> Hallucinations, <input type="checkbox"/> Nervous Breakdown, <input type="checkbox"/> Unhappy	
		Hematologic/ Lymphatic	<input type="checkbox"/> Blood Clots, <input type="checkbox"/> Bleeding Problems, <input type="checkbox"/> Easy Bruising, <input type="checkbox"/> Transfusion, <input type="checkbox"/> Enlargement Lymph Node, <input type="checkbox"/> Pain, <input type="checkbox"/> Swelling, <input type="checkbox"/> Varicosities, <input type="checkbox"/> Anemia, <input type="checkbox"/> Blood Thinners	
		Musculoskeletal	<input type="checkbox"/> Fracture, <input type="checkbox"/> Arthritis, <input type="checkbox"/> Motion Loss, <input type="checkbox"/> Cramps/Spasms, <input type="checkbox"/> Dislocation, <input type="checkbox"/> Muscle Weakness	
		Allergic/Immunologic	<input type="checkbox"/> Dermatitis, <input type="checkbox"/> Hay Fever, <input type="checkbox"/> Migraine, <input type="checkbox"/> Sensitivity to Pollen	

Family History (Mark any conditions that your parents or siblings have or have had by indicating the family member [M = mother, F = Father, B = Brother, S = Sister] after the conditions):

High Blood Pressure:	Asthma:	Cancer:
Heart Attack:	Lung Disease:	Stroke:
Coronary Artery Disease:	Tuberculosis:	Diabetes:
Heart Valve Disease:	Thyroid Disease:	Kidney Disease:
Irregular Heart Rhythm:	Blood Clots:	Arthritis:
Peripheral Vascular Disease:	Seizures:	Osteoporosis:
Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	Immunodeficiency:	Other:

I certify that the foregoing statements are true to the best of my knowledge.

Patient Signature: _____ Date: _____ Time: _____

Vital Signs:

Temp: _____ BP: _____ HR: _____ RR: _____ Pain: _____ Height: _____ Weight: _____ BMI: _____

Medical Assistant (Print): _____ (Signature): _____ Date: _____ Time: _____

PHYSICAL EXAMINATION:

Physician (Print): _____ (Signature): _____ Date: _____ Time: _____

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