General Medical and Personal Background

Last Name • First Name • Middle Initial • SSN/Insurance ID # • Date • Referring Provider

Age: ____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Domestic Partner ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Ethnicity: ☐ White or European ☐ Black ☐ Asian ☐ Middle Eastern ☐ Hispanic ☐ Other

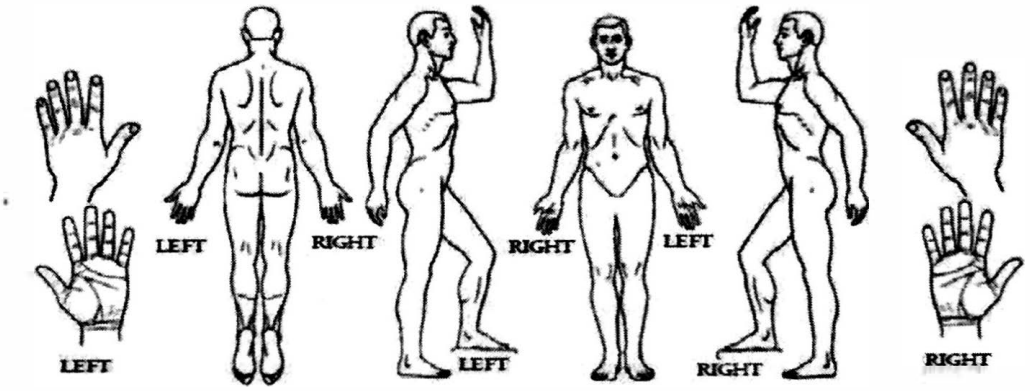
Dominant Hand: Right / Left / Both

PERSONAL HEALTH HISTORY

Mark the areas on your body where you now feel your typical pain. Include all affected areas.

Use the appropriate symbols indicated below.

ACHE	NUMBNESS	PINS & NEEDLES	STABBING
>>>>>>	----------	oooooooo	//////////



What problem/issue brought you here today? _____

How long has it been bothering you? What would you like to accomplish? _____

_____

Have you had a previous injury to this area? _____

What makes it worse? _____

What makes it better? _____

Please mark on the line below to describe the level of pain / discomfort you are having today.

No Pain _____ Worst Pain Ever

Pain feels: 0 1 2 3 4 5 6 7 8 9 10

☐ Dull ☐ Achy ☐ Burning ☐ Stabbing ☐ Numbness ☐ Tingling ☐ Pulling ☐ Cramping ☐ Tightness ☐ Other

Frequency:

☐ Constant ☐ Comes and Goes ☐ Getting Worse ☐ Getting Better ☐ Awakens Me at Night ☐ Other

Which of the following have you had for your low back/mid-back/neck?					Did the treatment make you:		
	Low Back	**Mid-Back**	**Neck**	**Other**	**Better**	**No Change**	**Worse**
Physical Therapy							
Occupational Therapy							
Chiropractic/Osteopathic							
Massage							
Brace							
Biofeedback							
Acupuncture							
Herbs							
Injections:							
Trigger Point							
Epidural/Facet							
Nerve Root							
Regular X-rays					Patient Label Here		
MRI Scan							
Myelogram							
CT Scan							
Bone Scan							
EMG/NCV							

Check all of those that apply to you:

1. Bowel Function: ☐ Normal ☐ Loss of control or accidents ☐ Constipation
2. Bladder Function: ☐ Normal ☐ Loss of control or accidents ☐ Difficulty starting/stopping urination __Sense of urgency
3. Leg / Foot: ☐ Normal ☐ Weakness (Right / Left)
4. Arm / Hand: ☐ Normal ☐ Weakness (Right / Left)

It is normal for patients faced with daily pain to experience emotional reactions such as worry, frustration and sadness. Please circle the appropriate number to indicate the extent that you are troubled by the following:

	NONE									**SEVERE**
Anxiety	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9 ☐ 10
Depression	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9 ☐ 10
Irritability	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9 ☐ 10

☐ Yes ☐ No | Was this a problem for you prior to having the pain for which you are seeing us today?
☐ Yes ☐ No | If so, is it worse since developing this pain?
☐ Yes ☐ No | Do you currently take medication for anxiety or depression?
☐ Yes ☐ No | Have you received counseling for anxiety or depression?
☐ Yes ☐ No | Do you have a history of psychological disease? (ie: ADD, Obsessive Compulsive Disorder, Bipolar, Schizophrenia)
Please specify: _____

PRIOR MEDICAL HISTORY

List **ALL allergies** to medications:

MEDICATION	**REACTION**	**MEDICATION**	**REACTION**

List **ALL** medications **(prescription and non-prescription)** you currently take:

MEDICATION NAME	**DOSAGE**	**MEDICATION NAME**	**DOSAGE**

List all medications **previously** taken for your pain _____

Gastrointestinal: ☐ Do you have ulcers? ☐ Yes ☐ No Has your ulcer bled? ☐ Yes ☐ No

☐ Do you have reflux, hiatal hernia or GERD? ☐ Yes ☐ No

Alcohol / Drugs: What is your approximate weekly use of alcoholic beverages?

☐ I don't drink alcohol

☐ Less than 1-2 drinks a week

☐ 3-6 drinks a week

☐ Drink some alcohol on a daily basis

Have you or a parent ever had a problem with:

Alcoholism: ☐ You ☐ Parent ☐ No • Drug Abuse: ☐ You ☐ Parent ☐ No

Tobacco: What is your approximate daily use of tobacco?

☐ I don't smoke ☐ 1 pack per day ☐ More than 2 packs per day

☐ ½ pack per day ☐ 1-2 packs per day

OB/GYN: (Women Only)

Date of last menstruation: _____ ☐ Normal ☐ Abnormal ☐ Hysterectomy/Postmenopausal/Premenopausal

Date of last pelvic exam: _____ ☐ Normal ☐ Abnormal

Date of last PAP Smear: _____ ☐ Normal ☐ Abnormal

Pregnant or possibly pregnant ☐ Yes ☐ No Breast Feeding ☐ Yes ☐ No

CURRENT MEDICAL PROBLEMS: Please list

1) _____ 4) _____ 7) _____

2) _____ 5) _____ 8) _____

3) _____ 6) _____ 9) _____

PRIOR SURGERIES: Please list

TYPE	DATE	TYPE	DATE

FAMILY HISTORY:

	Living (Yes/No)	Current health issues or cause of death
Father	Yes☐ No☐	_____
Mother	Yes☐ No☐	_____
Spouse	Yes☐ No☐	_____
Brothers #	Living ____ _	_____
#	Deceased ____	_____
Sisters #	Living ____ _	_____
#	Deceased ____	_____
Children #	Living ____ _	_____
#	Deceased ____	_____

Review of Systems: please put an "X" next to any of the symptoms you have had during the past 2 months.

- ☐ Nausea
- ☐ Vomiting
- ☐ Chills
- ☐ Problems with sexual function
- ☐ Loss of sensation around groin or buttocks
- ☐ Unexplained fevers
- ☐ Night sweats
- ☐ Weight loss of 10 pounds or more
- ☐ Loss of appetite
- ☐ Excessive fatigue
- ☐ Problems with depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Decreased Concentration
- ☐ Memory Difficulties
- ☐ Unusual stress in home life
- ☐ Unusual stress in work life
- ☐ Any lumps in neck, armpits, groin
- ☐ Chest pain or tightness
- ☐ Persistent or unusual cough
- ☐ Trouble breathing with exercise
- ☐ Trouble breathing lying flat
- ☐ Stomach pain
- ☐ Swollen ankles
- ☐ Joint pain or swelling
- ☐ List joints: _____
- ☐ Muscle tenderness
- ☐ Generalized morning stiffness
- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Change in bowel habits
- ☐ Persistent diarrhea
- ☐ Excessive constipation
- ☐ Dark black stools
- ☐ Blood in stools
- ☐ Pain or burning when urinating
- ☐ Blood in urine
- ☐ Need to urinate more at night
- ☐ Persistent eye redness
- ☐ Dry eyes or mouth
- ☐ Skin rashes

Work: Employer: _____ Your Job Title: _____ Date last worked: _____

Work status at the time of:	Injury Onset	Currently
On disability	☐	☐
Regular: full-time	☐	☐
Regular: part-time	☐	☐
Permanent light duty	☐	☐
Temporary light duty	☐	☐
Temporarily Disabled (not working)	☐	☐
Retired	☐	☐

How physically demanding is your job?

- ☐ Very heavy (frequently lifting > 100 pounds)
- ☐ Heavy (frequently lifting > 60 pounds)
- ☐ Moderate (frequently lifting > 30 pounds)
- ☐ Light (frequent lifting < 30 pounds)
- ☐ Sedentary (essentially no lifting)

How satisfied are you with your job?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ It is the worst job I've ever had

Social: What are some of your usual recreational activities that you had participated in the **YEAR BEFORE** your current problem? **Place an "X" in front of those you currently cannot perform.**

(☐) _____ (☐) _____

(☐) _____ (☐) _____

Education: (Highest level attained) ☐ Did Not Finish High School ☐ High School ☐ College ☐ Post Graduate

Attorney: Does an attorney assist you with your injury claim? ☐ Yes ☐ No Name: _____

Primary Care Physician: Name: _____

Address: _____

Please inform me if any portion of the physical examination that I will perform causes you pain. Please do not perform any motion that causes your symptoms to worsen. An initial evaluation will occasionally increase your symptoms since painful structures are being evaluated.

Please sign and date this form.

_____ _____

Patient signature Date