General Medical and Personal Background

______________________________________ • ________________ • ____________ • ____________

Last Name First Name Middle Initial Insurance ID# Date Referring MD

DOB:________________ Age:_______ Gender: Male Female

Marital Status:

Ethnicity:

Dominant Hand:

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 concussion/brain injury?____
What makes your symptoms worse? ____

What makes them better?____

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

Your pain feels: No Pain — Worst Pain Ever

0 1 2 3 4 5 6 7 8 9 10

Please describe the timing of your pain:

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

SYMPTOMS	Mild Symptoms 1-2; Mod Symptoms 3-4; Severe Symptoms 5-6							
Headache	0	1	2	3	4	5	6	
Nausea	0	1	2	3	4	5	6	
Vomiting	0	1	2	3	4	5	6	
Balance Problems	0	1	2	3	4	5	6	
Dizziness	0	1	2	3	4	5	6	
Fatigue	0	1	2	3	4	5	6	
Trouble falling asleep	0	1	2	3	4	5	6	
Excessive sleep	0	1	2	3	4	5	6	
Loss of sleep	0	1	2	3	4	5	6	
Drowsiness	0	1	2	3	4	5	6	
Light sensitivity	0	1	2	3	4	5	6	
Noise sensitivity	0	1	2	3	4	5	6	
Irritability	0	1	2	3	4	5	6	
Sadness	0	1	2	3	4	5	6	
Nervousness	0	1	2	3	4	5	6	
More emotional	0	1	2	3	4	5	6	
Numbness	0	1	2	3	4	5	6	
Feeling "slow"	0	1	2	3	4	5	6	
Feeling "foggy"	0	1	2	3	4	5	6	
Difficulty concentrating	0	1	2	3	4	5	6	
Difficulty remembering	0	1	2	3	4	5	6	
Visual problems	0	1	2	3	4	5	6	

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	I0
Irritability	0	I	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____

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? Packs

I don' t smoke   l pack/ day   ½pack

More than 2/packs day   1-2 packs per day

CURRENT MEDICAL PROBLEMS: Please list

I) ____________________ 3) ____________________ 6) ____________________

2) ____________________ 4) ____________________ 7) ____________________

5) ____________________ 8) ____________________

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 year.

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 lump s 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: (Check 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's signature Date