

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Referring physician: \_\_\_\_\_

Office #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Why are you being seen today? \_\_\_\_\_

Where is your pain located? \_\_\_\_\_

When did the symptoms start? \_\_\_\_\_

Did your symptoms start with a fall/accident/gradual? (circle one)

Duration of symptoms? \_\_\_\_\_ months/years

What makes the pain worse?

What makes it better?

Are you on any medicine for the pain?

Describe your pain. (please circle)

Sharp	Yes/No
Dull	Yes/No
Pins and needles	Yes/No
Constant	Yes/No
Pain at Night	Yes/No
Comes and goes	Yes/No
Radiate	Yes/No

Past Medical History (circle all that apply)

Heart attack	Psychiatric	Congestive Heart Failure
Hypertension	Diabetes	Kidney Failure
Bleeding Ulcer	Hepatitis	Stroke
Asthma	Blood clot	Colitis
Emphysema	Peptic Ulcer	Gastric Reflux
Cancer (type) _____		Other (please list)

(Please continue on next page.)

**Family History (circle all that apply)**

Rheumatoid arthritis

Cancer

Diabetes

**Previous Surgeries (please list all)      Year/Procedure**

**Medications**

**Allergies**

**Do have the following ? (circle all that apply)**

Reading glasses

Change of vision

Loss of hearing

Hoarseness

Nosebleeds

Cough

Fever/Chills

Difficulty Swallowing

Chest pain

Swollen ankles

Poor appetite

Nausea/vomiting

Stomach pain

Ulcer

Diarrhea

Rash

Burning on urination

Headaches

Seizures

Married? Yes/No      Smoke? Yes/No    \_\_\_ packs per day for \_\_\_ years

Live alone? Yes/No      Drink Alcohol? Yes/No      How much? \_\_\_\_\_

Are you currently working? Yes/No      What type of job? \_\_\_\_\_

On you currently on disability? Yes/No      Last worked? \_\_\_\_\_

Is there workers compensation or litigation related to your condition? Yes/No

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date