



Patient Name: _____ Date of Birth: _____

Marital Status: Single Married Divorced Widowed

Height: _____ Weight: _____

Referring Doctor: _____ Primary Care Dr.: _____

Preferred Pharmacy: (name/address) _____

ALLERGIES:

Do you have any drug allergies? Yes No

If yes, please describe the allergy and the reaction: _____

Do you have any other allergies we should know about? Yes No

If yes, please describe the allergy and the reaction: _____

FAMILY HISTORY:

Family Member	Alive/Deceased	Age	Medical Problems
Mother	A D		
Father	A D		
Sister/Brother (Please circle)	A D		
Sister/Brother (Please circle)	A D		
Sister/Brother (Please circle)	A D		
Sister/Brother (Please circle)	A D		

Are there diseases which are common in your family? _____

Has any family member had a history of surgery for their back or neck, or had problems with their back or neck? _____

PAST MEDICAL HISTORY: Please check yes or no.

- | | |
|---|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> Use of Blood Thinners | Yes <input type="checkbox"/> No <input type="checkbox"/> Head Injury, with skull fracture |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Anxiety Disorder | Yes <input type="checkbox"/> No <input type="checkbox"/> Head Injury, without skull fracture |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Aortic Aneurysm | Yes <input type="checkbox"/> No <input type="checkbox"/> HIV |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Arthritis | Yes <input type="checkbox"/> No <input type="checkbox"/> High Cholesterol |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Asthma | Yes <input type="checkbox"/> No <input type="checkbox"/> High Blood Pressure |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Bipolar Disorder | Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Attack |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Cancer _____ | Yes <input type="checkbox"/> No <input type="checkbox"/> Osteoarthritis |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Congestive Heart Failure | Yes <input type="checkbox"/> No <input type="checkbox"/> Osteoporosis |
| Yes <input type="checkbox"/> No <input type="checkbox"/> COPD (Chronic Obstructive Pulmonary Disease) | Yes <input type="checkbox"/> No <input type="checkbox"/> Rheumatoid Arthritis |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Coronary Artery Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> Seizure Disorder |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Stroke (CVA) | Yes <input type="checkbox"/> No <input type="checkbox"/> Thyroid Disease |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Degenerative Joint Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> Tuberculosis |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Depression | Yes <input type="checkbox"/> No <input type="checkbox"/> Vertebral Artery Stenosis |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Diabetes | Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____ |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Fibromyalgia | Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____ |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Glaucoma | Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____ |

Complications from any surgery? Yes No Please explain: _____

Do you take antibiotics before procedures? Yes No Why: _____

PAST SURGICAL HISTORY: Please list all previous surgical procedures and **date** your surgery was performed.

- | | |
|---|---|
| <input type="checkbox"/> Carpal Tunnel _____ | <input type="checkbox"/> Spinal Cord Injury _____ |
| <input type="checkbox"/> Craniotomy _____ | <input type="checkbox"/> Spinal Cord Stimulator _____ |
| <input type="checkbox"/> Disectomy _____ | <input type="checkbox"/> Spinal Fusion-Cervical _____ |
| <input type="checkbox"/> Endarterectomy _____ | <input type="checkbox"/> Spinal Fusion-Lumbar _____ |
| <input type="checkbox"/> Intrathecal Pump _____ | <input type="checkbox"/> Spinal Fusion-Thoracic _____ |
| <input type="checkbox"/> Kyphoplasty _____ | <input type="checkbox"/> Ulnar Nerve Release _____ |
| <input type="checkbox"/> Laminectomy-Cervical _____ | <input type="checkbox"/> Vertebroplasty _____ |
| <input type="checkbox"/> Laminectomy-Lumbar _____ | |
| <input type="checkbox"/> Other _____ | |
| _____ | |
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Hysterectomy _____ |
| <input type="checkbox"/> C-Section _____ | <input type="checkbox"/> Sinus Surgery _____ |
| <input type="checkbox"/> Gall Bladder Removal _____ | <input type="checkbox"/> Pancreatic Surgery _____ |
| <input type="checkbox"/> Dental _____ | <input type="checkbox"/> Prostatectomy _____ |
| <input type="checkbox"/> D & C _____ | <input type="checkbox"/> Large Bowel Resection _____ |
| <input type="checkbox"/> Eye Surgery _____ | <input type="checkbox"/> Small Bowel Resection _____ |
| <input type="checkbox"/> Fracture Repair _____ | <input type="checkbox"/> Stomach Resection _____ |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Rotator Cuff Repair _____ |
| <input type="checkbox"/> Angioplasty _____ | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Bypass _____ | <input type="checkbox"/> Subtotal _____ |
| <input type="checkbox"/> Stent _____ | <input type="checkbox"/> Total _____ |
| <input type="checkbox"/> Valve Replacement _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Tubal Ligation _____ |
| <input type="checkbox"/> Hernia Repair _____ | <input type="checkbox"/> Vasectomy _____ |
| <input type="checkbox"/> Other _____ | |

SOCIAL HISTORY:

Occupation: _____

A: Do you consider your job: Heavy Moderate Light

B: If retired, what was your prior occupation? _____

Is someone available to care for you in your home if the need arises? Yes No

Do you live in a: House Apartment Other: _____ # of stories: 1 2 3

Do you exercise regularly? Yes No Describe: _____

Do you have a history of drug abuse or drug addiction? Yes No

Alcohol Use:

I use alcohol: Never Rarely Weekly Daily

I have a history of heavy alcohol use: Yes No

Tobacco Use:

Do you smoke? Yes No

I currently smoke ___ packs per day and have for ___ years.

I smoked in the past ___ packs per day for ___ years.

Are you at risk for AIDS (e.g. sexual history, drug use, previous transfusion)? Yes No

CURRENT MEDICATIONS: Please list all.

Medication	Dose	Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

REASON FOR VISIT:

Describe your current problem and how it began. Please list all symptoms leading to today's visit:

Date symptoms began: _____

Is your current problem a result of: Car Accident Work Accident Other/Unknown

Date of injury/accident: _____

Are you currently off work because of your problems? Yes No

Is a lawyer involved in your case? Yes No If yes, name of lawyer: _____

PAIN HISTORY: (if not applicable, skip to next section)

What makes your symptoms better? _____

What makes your symptoms worse? _____

What specific activities are you having difficulty with that you hope to change as a result of treatment? _____

In order to get better, you will be expected to participate in your treatment. This may include doing exercises or avoiding certain activities. How committed are you to participating in your treatment?

Very committed Somewhat committed Not very committed

Is there anything that will limit your ability to participate in therapies? Yes No

Explain: _____

What tests have you had done for your problem? X-rays CT scan MRI Blood tests

Other: _____

What treatments have you had for your problem? Medications Physical Therapy

Chiropractic Injections Surgery Other _____

Please describe their effect: _____

Would you consider surgery if it were recommended? Yes No

REVIEW OF SYSTEMS: Please check yes or no.

General:

- Yes No Weight Gain greater than 10 lbs.
- Yes No Weight Loss greater than 10 lbs.
- Yes No Obesity

Skin:

- Yes No Bruising

HEENT:

- Yes No Blurred Vision
- Yes No Headache
- Yes No Head Injury
- Yes No Double Vision
- Yes No Visual Disturbances
- Yes No Visual Loss
- Yes No Hearing Loss
- Yes No Ringing in the Ears
- Yes No Seasonal Allergies
- Yes No Hoarseness

Neck:

- Yes No Neck Mass
- Yes No Swollen Glands

Respiratory:

- Yes No Chronic Cough
- Yes No Difficulty Breathing

Breast:

- Yes No Nipple Discharge

Cardiovascular:

- Yes No Chest Pain
- Yes No Irregular Heart Beat
- Yes No Elevated Blood Pressure
- Yes No Rapid Heart Rate
- Yes No Shortness of Breath
- Yes No Swelling of the Feet

Gastrointestinal:

- Yes No Change in Bowel Habits
- Yes No Indigestion
- Yes No Jaundice
- Yes No Nausea
- Yes No Vomiting

Genitourinary:

- Yes No Change in Bladder Habits
- Yes No Frequency
- Yes No Hesitancy
- Yes No Incontinence

Musculoskeletal:

- Yes No Back Pain
- Yes No Muscle Cramps
- Yes No Arm Weakness
- Yes No Arm Pain
- Yes No Leg Weakness
- Yes No Leg Pain
- Yes No Neck Pain
- Yes No Neck Stiffness

Neurological:

- Yes No Decreased Memory
- Yes No Difficulty Speaking
- Yes No Dizziness
- Yes No Fainting
- Yes No Headaches
- Yes No Incoordination
- Yes No Loss of Consciousness
- Yes No Seizures
- Yes No Stroke
- Yes No Weakness in Extremities
- Yes No Leg Pain with Walking

Psychiatric:

- Yes No Anxiety
- Yes No Depression
- Yes No Inability to Concentrate

Endocrine:

- Yes No Thyroid Problems

Hematology:

- Yes No Abnormal Bleeding
- Yes No Anemia
- Yes No Blood Clots

Other: _____

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE

Patient signature

Date

I HAVE REVIEWED THE ABOVE INFORMATION

Physician Signature

Date

Physician Name (printed)

Date reviewed & initials

Date reviewed & initials

Date reviewed & initials

Date reviewed & initials

Date reviewed & initials