

CURRENT MEDICAL PROBLEM

Name of Patient _____ Age _____ Sex _____ Today's Date _____
Birth date _____

Consulting Doctor (Name of doctor who sent you here): _____

Primary Care Doctor: _____

Dominant Hand
 R L

Please tell us why you are here today: _____

Where is your pain (problem): _____

Was there an accident or injury: _____

Does this condition affect your Right Side Left Side Is this work related? No Yes

When did this start: _____

What is the pain like: _____

Is the pain constant or intermittent ?

What makes it worse: _____

What makes it better: _____

Is it getting: Better Worse

What other symptoms do you have: _____

Have you had any treatment for this to this date: No Yes By whom: _____

If so, please indicate treatment by marking the appropriate box:

Therapy Injections Surgery Hospitalization Chiropractic Acupuncture Brace

How has this been evaluated:

X-rays Cat Scan MRI EMG's Bone Scan Discogram

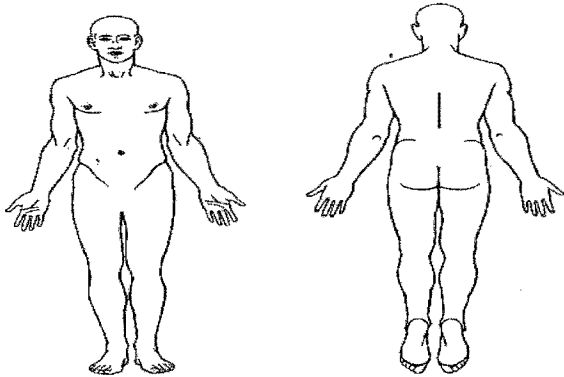
Have you tried any medication for this problem? No Yes Please list: _____

Diagram

(mark parts of your body where you feel the problem. Use the appropriate symbols indicated below)

Ache X Stabbing ////
Swelling ▭ Numbness ○
Pins/Needles ⋈ Popping, Cracking, Grinding △

Your Approx. Height _____



Right Left Left Right
Front Back

Severity of pain: 10 being worst

---/---/---/---/---/---/---/---/---/---/---
1 2 3 4 5 6 7 8 9 10

For office use only:		
Date _____	WT _____	
P _____	T _____	IN _____

I certify to the best of my knowledge that the above information is correct

Patient/Gaurdian Signature _____ Date: _____

I have reviewed and agree with the findings as noted Physicians Signature: _____

PAST MEDICAL INFORMATION

Name of Patient _____ Age _____ Sex _____ Today's Date _____
Birth date _____

List Medical Conditions: **(IMPORTANT - PLEASE LIST ALL MEDICAL CONDITIONS)**

List Your Medications:

Are you **allergic** or **sensitive** to any medications or other substances? Yes No Metals Latex
If so, please list allergy and reaction: _____

Past Surgical History: Have you ever been operated on for any condition? Yes No

Procedure	Date	Procedure	Date
<input type="checkbox"/> Orthopedic	_____	<input type="checkbox"/> Hernia Repair	_____
<input type="checkbox"/> Tonsillectomy	_____	<input type="checkbox"/> Gall Bladder	_____
<input type="checkbox"/> Cataracts	_____	<input type="checkbox"/> Hysterectomy	_____
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> C Section	_____
<input type="checkbox"/> Bladder /or Prostate	_____	<input type="checkbox"/> Cardiac/Bypass Surgery	_____
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Other	_____

Have you ever had general anesthesia? NO YES Have you or your family had any problems with anesthesia? NO YES

Review of Symptoms: Are you (or the child) currently having or have had problems with your (check boxes that are positive and explain):

Constitutional:	NO	YES	Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Other: _____
Eyes:	NO	YES	Blurred vision <input type="checkbox"/> Glasses <input type="checkbox"/> Other: _____
Ears, Nose, Throat:	NO	YES	Congestion <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Other: _____
Lungs, Breathing:	NO	YES	Shortness of breathe <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Other: _____
Heart:	NO	YES	Hypertension <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Other: _____
Gastrointestinal:	NO	YES	Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other: _____
Bladder:	NO	YES	Incontinence <input type="checkbox"/> Urinary tract infection <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Have loss of control or accidents <input type="checkbox"/> Have a loss of sensation around groin or buttocks <input type="checkbox"/> Other: _____
Endocrine:	NO	YES	Diabetes <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Other: _____
Musculoskeletal:	NO	YES	Joint pain <input type="checkbox"/> Leg pain <input type="checkbox"/> History of broken bones <input type="checkbox"/> Other: _____
Bleeding problems:	NO	YES	Blood Clots/DVT <input type="checkbox"/> Prolonged bleeding after cut/injury <input type="checkbox"/> Other: _____
Neurological:	NO	YES	Numbness/tingling <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Frequent falls <input type="checkbox"/> Other: _____
Integumentary:	NO	YES	Rashes <input type="checkbox"/> Skin disorders <input type="checkbox"/> Other: _____
Psychiatric:	NO	YES	Change in mood <input type="checkbox"/> Change in sleep patterns <input type="checkbox"/> Other: _____
Immunologic/Allergic:	NO	YES	Asthma <input type="checkbox"/> Chronic rashes <input type="checkbox"/> Hay fever <input type="checkbox"/> Other: _____

Social History

Occupation: _____
Do you currently smoke? No Yes
Have you ever smoked? No Yes If yes, how long ago did you quit? _____
Do you consume any alcohol? No Yes If yes, how often? _____
Single Married Divorced Widowed # of children _____

Is there a **family history** of: High Blood Pressure Heart Disease Diabetes Cancer Hyperthermia
Deep Venous Thrombosis Pulmonary Embolus None

I certify to the best of my knowledge that the above information is correct: _____ Reviewed: _____

Patient/Guardian Signature _____
Date: _____

I have reviewed and agree with the findings as noted Physicians Signature: _____