

CONFIDENTIAL PATIENT INFORMATION/ MAJOR MEDICAL

Name _____ S.S.N. _____ Date _____

Address _____ City/State _____ ZIP _____

D.O.B _____ Height/Weight _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

Message phone or Cell Phone _____ Spouse/Partner Name _____

Whom may we thank for referring you to us _____

Emergency Contact _____ ER Contact Phone # _____

Purpose for visit _____ Date of onset _____

Symptoms developed from: Work Injury ____ Auto Accident ____ Other _____

Have you ever had similar symptoms? (dates) _____

Have you ever had pain in other areas of your spine? (dates) _____

Dates of previous auto accidents _____

List surgical operations w/ dates _____

List any medications you are on _____

Other doctors consulted for this condition? (dates) _____

Do you have a past history of injuries involving: (dates) ankles _____ knees _____

hips _____ wrists _____ elbows _____ shoulders _____

Have you had X-Rays taken of your spine in the last 7 years? _____

Family History: (List any significant diseases, i.e.: diabetes, cancer, etc.) Are you adopted? _____

Mother _____ Father _____

Grandparents _____ Aunt/Uncle/Siblings _____

Dates of last physical exam _____ Any unusual findings _____

Do you exercise regularly? _____ Types and How often? _____

Men: Date of last prostate exam _____ Date of last colon exam _____

Any unusual Findings _____

Women: Date of last pap smear _____ Date of last mammogram _____

Any unusual findings _____

Are you pregnant? _____ Due Date _____ Trying to get pregnant? _____

Do you have children? _____ How many? _____

Do you have breast implants? _____ Date implanted _____

Chief Complaint _____

ONSET (what were you doing when injury occurred) _____

PROVOKING (what activities aggravate your injury) Circle- Sitting / Standing / Lying / Walking / Reaching/ Bending / Other _____

PALLIATIVE (what makes it feel better) Circle- Ice / Heat / Lying / Pain Med. / Stretching / Other _____

QUALITY (describe the pain) Circle- Sharp / Electric / Burning / Stabbing / Aching / Deep / Other _____

Any sensations radiating into the following -Circle- Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades / Other _____

Describe the radiating -Circle- Sharp / Dull / Tingling / Numbness / Prickling / Other _____

SEVERITY On a scale of 0-10 with 0 being no pain and 10 pain prevents ALL activities _____

PATTERN (time of day most aggravated) Circle- Early Morning / Mid Day / Late Eve / After Work / After Exercise / Other _____

CHECK ANY OF THE FOLLOWING YOU ARE CURRENTLY EXPERIENCING

HEAD

- Headache
- Allergies
- Dizziness
- Deafness
- Ringing in Ears
- Loss of Balance

- Fainting
- Eye Pain
- Failing Vision
- Nosebleeds
- Sinus Infection

CHEST

- Chest Pain
- Difficulty Breathing
- Asthma

OTHER

- Loss of Sleep
- Nervousness
- Depression
- Fever
- HIV+/Aids
- Change in Menstrual Cycle
- Pregnant
- Hemorrhoids
- Other _____

ABDOMEN

- Difficult Digestion
- Abdominal Cramps
- Diarrhea
- Constipation
- Nausea
- Change in Urinary Function
- Change in Bowel Function

PLEASE GIVE DATES FOR ANY OF THE FOLLOWING YOU'VE HAD

- | | | |
|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Colitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Eczema | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Stone/
Infection |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Malaria | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Whooping Cough | |

Signature _____ Date _____