

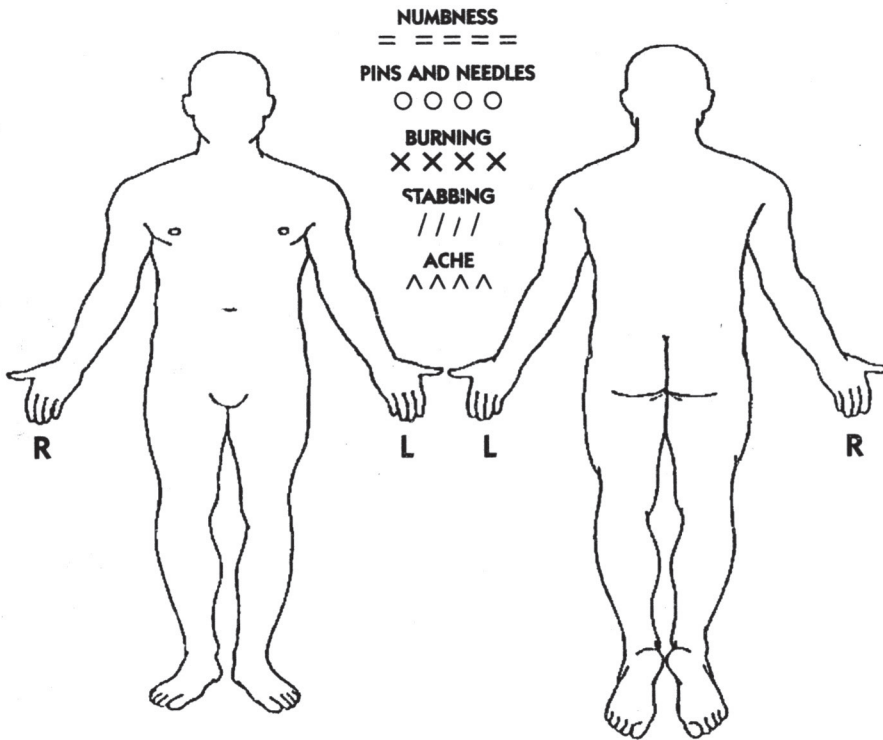


Patient History Form

Name: _____ Age: _____ Sex: Male Female Height _____ Weight _____ Date of birth _____
 Physician who sent you: _____ Primary physician: _____
 Employer: _____ Job title: _____ How long have you worked there? _____
 When did your pain start? _____ Date of injury: _____ How did symptoms start? _____

Pain began: Suddenly Gradually Chronic Related to: Job Accident Unsure Other: _____

WHERE IS YOUR PAIN NOW? Mark all that apply:



WHAT MAKES SYMPTOMS:

| | worse | better |
|---------------------|--------------------------|--------------------------|
| Walking | <input type="checkbox"/> | <input type="checkbox"/> |
| Standing | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting | <input type="checkbox"/> | <input type="checkbox"/> |
| Lying down | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending | <input type="checkbox"/> | <input type="checkbox"/> |
| Bowel Movement | <input type="checkbox"/> | <input type="checkbox"/> |
| Driving | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing / Sneezing | <input type="checkbox"/> | <input type="checkbox"/> |
| Rising from Sitting | <input type="checkbox"/> | <input type="checkbox"/> |
| Home Remedy | <input type="checkbox"/> | <input type="checkbox"/> |

VISUAL ANALOG SCALE

Please indicate on the scale below your level of pain, with 10 being the worst. Use an "X" to indicate your most severe pain, and use an "O" to indicate your average amount of pain.

RATE YOUR PAIN:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Pain in arm(s) / leg(s) compared to neck / back: more than same as less than

Is there weakness of your arms / legs? Yes No

How long can you sit with no / minimal pain? _____ minutes How long can you stand with no / minimal pain? _____ minutes

How far can you walk with no / minimal pain? _____

Have you had trouble controlling your bowels or bladder? Yes No If yes, is this a new problem? Yes No

What treatments have you had for this pain? medications physical therapy chiropractic steroid injections
 home / pool exercises alternative treatments (massage therapy, acupuncture, magnets, etc.) surgery

What studies have you had for your symptoms: X-rays CT scan MRI Bone Scan Myelogram
 EMG / Nerve test Blood work Discogram Other (list) _____

Continued on Other Side

Medical History

Medication allergies and type of reactions: _____

Are you allergic to contrast (kidney) dye? Yes No Uncertain

Medications (list): _____

Current Medical Problems (check all that apply):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> heart disease or heart attack | <input type="checkbox"/> diabetes | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> liver or kidney problems |
| <input type="checkbox"/> pacemaker or heart valve. | <input type="checkbox"/> blood clots / DVT | <input type="checkbox"/> depression | <input type="checkbox"/> AIDS / HIV |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> ulcers or reflux | <input type="checkbox"/> arthritis / gout | <input type="checkbox"/> neuropathy |
| <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> emphysema / COPD | <input type="checkbox"/> bleeding condition | <input type="checkbox"/> cancer (list type / location) _____ |
| <input type="checkbox"/> stroke | <input type="checkbox"/> asthma | <input type="checkbox"/> pancreatitis | _____ |
| <input type="checkbox"/> seizures <input type="checkbox"/> osteoporosis | <input type="checkbox"/> glaucoma | <input type="checkbox"/> other (list) _____ | _____ |

Surgical History (list type, date of surgeries): _____

Social History: married separated / divorced single widowed

Tobacco use: none smoke _____ packs per day _____ years smoked chewing tobacco / snuff cigars

Did you ever smoke? Yes No If yes, when did you quit? _____

Alcohol use: none occasional / social daily Last grade completed: _____

Family History: Please check if any family members (grandparents, parents or siblings) have had any of the following conditions:

- | | | | | | |
|---|--|--|--|--|---------------------------------|
| <input type="checkbox"/> neck or back problem | <input type="checkbox"/> heart disease | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> polycystic kidney disease | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> stroke |
| <input type="checkbox"/> blood disorders | <input type="checkbox"/> diabetes | <input type="checkbox"/> neuromuscular disease | <input type="checkbox"/> cancer (list types) | _____ | |

Review of Systems (please check Yes or No if you have had these in the last 6 months):

| | Yes | No | Yes | No | Yes | No |
|------------------------|-----|----|---------------|----|---------------------|----|
| General: | | | | | | |
| Weight loss | | | Fatigue | | Recurrent fevers | |
| Skin: | | | | | | |
| Rash | | | Ulceration | | Excess dryness | |
| Hematologic: | | | | | | |
| Bruising | | | Easy bleeding | | Swollen glands | |
| Head/Face: | | | | | | |
| Headaches | | | Hair loss | | Facial pain | |
| Eyes: | | | | | | |
| Blurry | | | Dry eyes | | Excess tearing | |
| ENT: | | | | | | |
| Ringling ears | | | Bloody noses | | Trouble swallowing | |
| Heart: | | | | | | |
| Chest pain | | | Racing heart | | Leg swelling | |
| Lung / Chest: | | | | | | |
| Coughing | | | Congestion | | Short of breath | |
| GI: | | | | | | |
| Tarry Stools | | | Bloody stools | | Abdominal pain | |
| Urinary: | | | | | | |
| Frequency | | | Bloody urine | | Burning | |
| Reproductive: | | | | | | |
| Pelvic pain | | | Testes pain | | Painful intercourse | |
| Mus / Skeletal: | | | | | | |
| Muscle pain | | | Joint pain | | Joint swelling | |
| Neurologic: | | | | | | |
| Dizziness | | | Weakness | | Unsteady walking | |
| Psychiatric: | | | | | | |
| Depression | | | Anxiety | | Mood swings | |

All others reviewed and negative

Other symptoms (please list): _____

The information contained in this health history form is true and accurate to the best of my knowledge.

Signature of patient or responsible party _____

Date _____

Physician Signature _____

Date _____