

Patient History

Evaluating Physician: _____

Name _____ Age _____ DOB _____

Address _____ Phone _____

Emergency Contact _____

Emergency Contact Phone _____ Relationship to Patient _____

Referring Physician Name/Phone _____

Insurance Name/Policy # _____

Chief Complaint

Where is the pain located on your body? _____

How long have you had the pain? _____

History Of Present Illness

Is the pain the result of a specific injury? Yes No

If yes, how and when did the injury occur? _____

Have you used a walker or cane since this incident or prior on a regular basis? _____

On a scale of 1-10 (10= most painful), how would you rate your pain over the last week? _____

Is the pain, constant or occasional

Would you describe it as: sharp dull aching throbbing stabbing

Is your pain radiating Yes No If yes, where? _____

Any loss of bladder or bowel control since the pain started? Yes No

What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you seen other physicians for these symptoms? Yes No

If yes, who did you see? Name/Address/phone _____

What treatments have you tried? Nothing Physical Therapy Exercise Acupuncture

Chiropractor Spine Injections Medications; list meds: _____

Risk Factors for Osteoporosis

Thin/small body frame Low calcium intake throughout lifetime

Family history of osteoporosis Anorexia

Post menopausal, especially if surgically induced Excessive alcohol use

Abnormal absence of menstrual periods History of smoking

Use of certain medications including corticosteroids and/or anticonvulsants

Have you ever had a bone scan? Yes No If yes, when and where? _____

Past Medical History

Asthma Depression High Cholesterol Mental Illness

Diabetes HIV Seizures Stroke

Blood Clots Kidney Disease Heart Disease High Blood Pressure

Cancer Hepatitis Liver Disease Ulcer

COPD Lung Disease Bleeding Problems

Other Conditions _____

Past Surgical History

Tonsillectomy Arthroscopy Hysterectomy Gallbladder

Appendectomy Hernia Repair Knee/Hip Replacement

Spine _____

Other _____

Patient Name _____ Date _____

Allergies

Are you allergic to any medication? Yes No

List medication allergies and type of reaction: _____

Medications Add attached sheet if necessary

Please list all medications including over the counter medications and dosages

Name of Medication	Dose	How Often Taken
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

Family History

Family Member	Alive	Deceased	Age	Medical Condition
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Children	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Social History

Occupation _____ Currently Working? Yes No
Highest Level of Education Completed: Elementary High School College Post-Grad
Are you currently on: Social Security Disability Workers Comp
Marital Status: Single Married Widowed Divorced Separated
Tobacco Use: Yes, I smoke _____ packs/day for _____ years.
 No, I quit _____ years ago after smoking _____ packs/day for _____ years.
 No, I have never used tobacco.
Alcohol Use: Yes, I drink Daily One or more/week One or more/month
 No, I quit using alcohol _____ years ago after drinking _____ days/week
 No, I have never used alcohol
Illicit Drug Use: Never Used Used _____ list _____

Previous Sedation Exposure

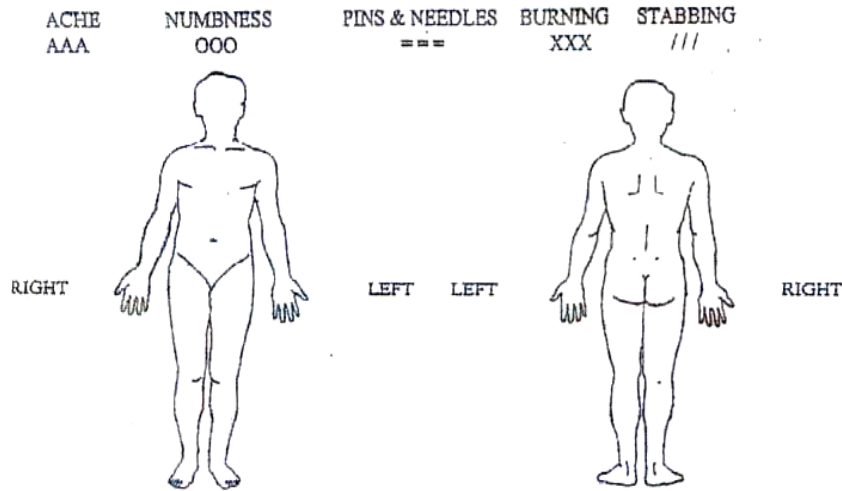
Have you ever been sedated for a medical procedure Yes No
If problems with sedation, please explain _____
Family history of sedation problem? _____

Review of Systems (please circle any problems or symptoms you may have had or currently have)

General: Recent illness, fever, chills, night sweats, weight loss/gain
Skin: Bruising, rashes, itching, skin cancer, other skin conditions _____
Cardiovascular: Shortness of breath, chest pain, palpitations, extremity swelling, murmur, angina
Respiratory: Chronic cough, wheezing, pain with breathing, productive cough
Gastrointestinal: Nausea, vomiting, diarrhea, constipation, heartburn, ulcer, blood in stool, jaundice
Neurological: Headaches, seizures, tremors, paralysis, loss of consciousness, dizziness
Musculoskeletal: Joint pain, tingling, burning, backache, neck ache, fatigue
Psychological: Anxiety, mood swings, constant crying, sleep loss, depression, suicidal thoughts

Patient Name _____ Date _____

Where is your pain now? Mark the area on your body where you feel the described sensations.



*****PHYSICIAN OFFICE TO FILL OUT REMAINDER OF FORM*****

Physical Exam

Height _____ Weight _____ V/S Temp _____ Respirations _____
B/P _____ Pulse _____ SAO2% _____ [] Right hand dominant [] Left hand dominant

Neuro: AAOX3, CNII-XII Intact
Resp: Lungs CTA= Bilat.
RRR-M/G/R, -JVD/Bruits, -Edema
BS + X4, -Organomegaly/Bruits
Musculoskeletal: -Kyphosis/Scoliosis/Tenderness
Skin- Intact no open wounds/bruising

Cervical

ROM F _____ E _____ RLB _____ LLB _____
Rotation R _____ L _____
DTR's [] 2+ symmetric in BUE except _____
Biceps (C5) R _____ L _____
Brachioradialis (C6) R _____ L _____
Triceps (C7) R _____ L _____
Motor [] 5/5 in BUE except _____

Sensation: R wnl/ _____
L wnl/ _____

Lumbar

ROM: F _____ E _____ RLB _____ LLB _____
Rotation: R _____ L _____
DTR's: [] 2+ symmetric in BLE except _____
Patella: (L3, L4) R _____ L _____
Achilles: (S1) R _____ L _____
Motor: [] 5/5 & symmetric in BLE except _____

SLR: [] pos [] neg R L B
Sensation: R wnl/ _____
L wnl/ _____

Babinski: down/up R L B
Gait normal, nonamb, antalgic, hemiplegic
Foot Drop: []No []Yes R L B
Clonus: []absent []present R L B

TESTS DATE FACILITY INTERPRETATION

[] X-ray _____
[] MRI _____
[] CT _____

Assessment and Plan _____

Patient instruction for follow up _____