

Patient Name: _____ Age: _____ Date: _____

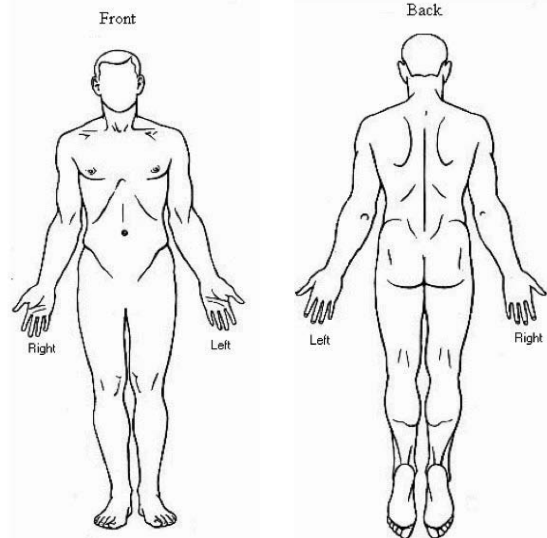
New Patient Form

Please complete all questions. All responses will remain confidential.

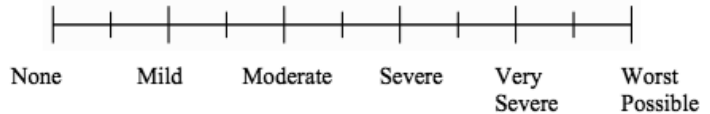
1. Please mark where your pain is on the diagram below:

Please indicate the percent of pain that you feel:

Neck/Back Pain		%
Arm/Leg Pain		%
Total	100	%



2. Please place an X on the hash mark that most accurately describes your pain NOW:



3. How long have you had this pain? _____

4. How did this pain begin?

- Auto accident On the job Unknown _____

5. What makes the pain worse?

- Sitting Standing Walking Lying down Nothing _____

6. What makes the pain better?

- Sitting Standing Walking Lying down Nothing _____

7. How far can you walk?

- < 100 yards > 100 yards

8. Please check all assistive devices that you use:

- Walker Cane Wheelchair

9. What treatments have you tried for this problem? (Check all that apply)

- Acupuncture Chiropractic Care Physical Therapy - # sessions _____
 Tylenol Anti-inflammatories (Aleve, Motrin, Advil, etc.) Muscle relaxants
 Pain medications (please list): _____
 Transforaminal epidural steroid injection Epidural steroid injection Facet joint injection

10. Which of the following are involved with your current pain/injury: (Check all that apply)

- Workers compensation Personal lawsuit Disability claim Social security claim



11. Is there anything else that you think we should know about? _____

Medical History

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart disease | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood clot/DVT/PE |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Gout | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Low thyroid | <input type="checkbox"/> Reflux/ulcers | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cancer(type:_____) | |
| <input type="checkbox"/> Other:_____ | | | |

Surgical History

Surgical Procedure	Date	Complication

Medications

Medication	Dose	Frequency

Allergies No known drug allergies _____

Social History Occupation: _____

Are you currently working? Yes No If yes, how many hours per week? _____

Marital status: Single Married Divorced Widowed

Do you have any children? Yes No If yes, how many? _____

Do you live alone? Yes No

Do you smoke? Yes No If yes, how many packs per day? _____

Do you chew tobacco? Yes No

Any illicit drugs? Yes No

Do you drink alcohol? Daily 1-2 x/week 1-2 x/month Rarely Never

Family History

Diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	DVT or PE (pulmonary embolus)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Malignant hyperthermia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mental health disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What type of cancer?	_____	

Review of Systems

Do you have any current (within the last few weeks) problems with:

Constitutional symptoms

Good general health	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unexplained weight change	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Eyes</i>		
Wear glasses or contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Change in vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Ears, nose, mouth, throat

Nose bleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swallowing difficulty	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Cardiovascular

Chest pains	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling of feet or ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sudden heartbeat changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Respiratory

Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent coughing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma or wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Gastrointestinal

Nausea or vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Change in bowel movements	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Genitourinary

Frequent urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Burning or painful urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood in urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Urinary incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Females only:

Painful periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Irregular periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Date of last menstrual period _____

Musculoskeletal

Joint pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joint stiffness or swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle pain or cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Integumentary

Rash or itching	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Change in skin, hair or nails	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Females only:

Breast pain or lumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Neurological

Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Psychiatric

Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sleep problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Endocrine

Heat or cold intolerance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excessive thirst or urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Hematologic/lymphatic

Easily bruise or bleed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Slow to heal after cuts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swollen glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Allergic/immunologic

Hay fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recurrent infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No