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NEW PATIENT INFORMATION

Name: _____ Age:_____ Date of birth:_____

Primary Care Physician:_____

(name, address & phone #)

Please list the spine concerns for which you are being seen today: _____

_____

When did your symptoms begin? _____

When are your symptoms at their worst? ☐Morning ☐Afternoon ☐Evening ☐Constant ☐Varies

Do you have bowel or bladder incontinence? ☐Yes ☐No

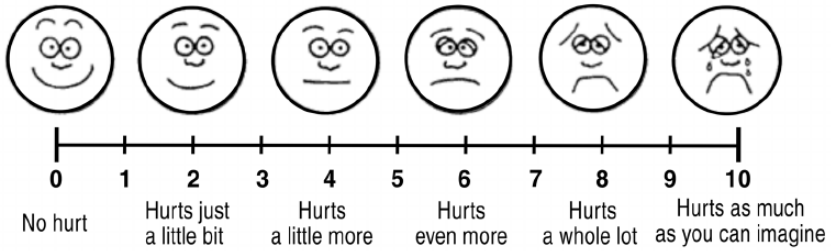
What activities or positions improve your symptoms? _____

_____

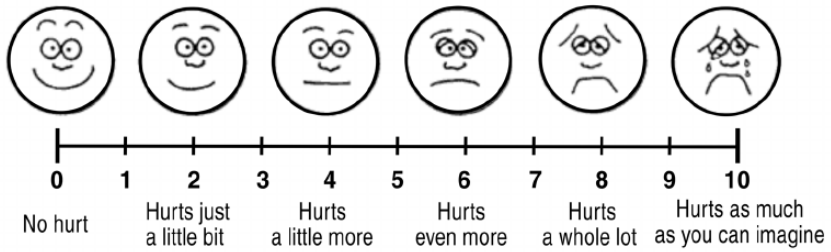
What activities or positions make your symptoms worse? _____

_____

Please rate your **back and/or leg** pain:



Please rate your **neck and/or arm** pain:



INJURY INFORMATION

Are your symptoms related to an injury? ☐Yes ☐No (if no, please proceed to the next section)

Describe the injury: _____

_____

_____

Is this a work-related injury? ☐Yes ☐No

Do you have an open Worker's Compensation case? ☐Yes ☐No ☐Pending

Current work status: ☐Working full time, full duty ☐Working full time, light duty ☐Off work

Is this injury the result of a motor vehicle accident? ☐Yes ☐No

State in which accident occurred: _____

Legal action? ☐None ☐Potential ☐Pending ☐Settled

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NEW PATIENT INFORMATION

NAME:_____

SPINE HISTORY

Have you had previous neck or back problems requiring treatment? ☐Yes ☐No

Have you had prior spine surgery? ☐Yes ☐No (If no, please proceed to the next section)

Number of neck surgeries: _____ Surgeon:_____ Date(s): _____

Number of back surgeries: _____ Surgeon: _____ Date(s): _____

DIAGNOSTIC TESTS

Which of the following tests have you had?

☐None ☐X-Ray ☐MRI ☐CT Scan ☐Myelogram ☐EMG ☐Bone Density ☐Bone Scan

☐Other: _____

FAMILY HISTORY

Do you have a family history of spine problems? ☐Yes ☐No ☐Unknown

SOCIAL HISTORY

With whom do you live? ☐Family/Spouse/Partner ☐Friends ☐Alone ☐Other _____

Do you use nicotine containing products? ☐Yes ☐No

If yes, please describe product and length of use (years):_____

Do you drink alcohol? ☐No ☐Rarely ☐Socially ☐Daily – type & quantity: _____

Work Status:

☐Employed <u>without</u> restrictions or limitations
☐Employed <u>with</u> restrictions or limitations
☐Temporarily not working due to pain
☐Not employed
☐On disability
☐Retired
☐Student
☐Other

PAST MEDICAL HISTORY

Please select any medical problems below that apply to <u>you</u>.

☐Anemia
☐Anxiety/Depression
☐Arthritis
☐Atrial Fibrillation
☐Asthma
☐Bleeding Tendency
☐Blood Clots
☐Diabetes
☐Heart Attack
☐Hepatitis
☐High Blood Pressure
☐High Cholesterol
☐HIV
☐MRSA
☐Pacemaker Placement
☐Pulmonary Embolism
☐Reflux
☐Seizures
☐Sleep Apnea
CPAP Settings_____
☐Stomach Ulcers
☐Stroke
☐Thyroid
☐Other_____

☐Cancer: Type & Location: _____

Cancer Disease State: ☐Active ☐In Remission Treatment: _____

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NEW PATIENT INFORMATION

NAME:_____

PAST SURGICAL HISTORY

Please select all that apply to you and indicate the year:

☐NONE
☐Appendectomy (Year _____)
☐Bypass/Open Heart (Year _____)
☐C-Section (Year _____)
☐Gall Bladder (Year _____)
☐Gastric Bypass (Year_____)
☐Hernia Repair (Year _____)
☐Hysterectomy (Year _____)
☐Joint Replacement (Year _____)
☐Shoulder Surgery (Year _____)
☐Other:
Type _____
Year _____

CURRENT MEDICATIONS

Please list **ALL** medications you are current taking (including over the counter meds and supplements)

☐**NONE**

MEDICATION	DOSEAGE	FREQUENCY	PRESCRIBER

Medication Allergies (Please list all medication allergies and reactions): ☐No known drug allergies

_____

_____

Pharmacy:_____

Do you have any allergies to: ☐Metal ☐Iodine ☐Shellfish ☐Latex

REVIEW OF SYSTEMS

Please check any of the following symptoms you are currently having:

☐Unexplained weight loss
☐Night sweats
☐Fevers/Chills
☐Rashes
☐Frequent/Easy bruising
☐Headache
☐Memory loss or confusion
☐Blurred/Double vision
☐Ringing in the ears
☐Vertigo/Dizziness
☐Chest pain
☐Shortness of breath
☐Nausea/Vomiting
☐Bloody/Dark stools
☐Burning/painful urination

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NEW PATIENT INFORMATION

NAME: _____

PAIN DIAGRAM

Mark the area of your body where you feel abnormal sensations and/or pain. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

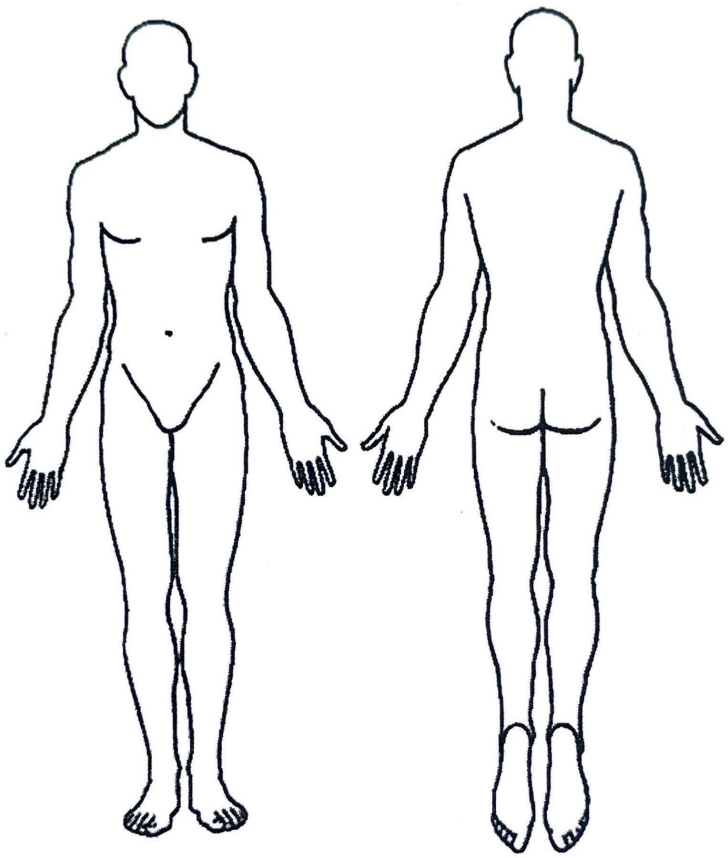
Numbness: ----------

Pins and needles: **********

Burning: xxxxxxxxxxxxxxxxx

Stabbing: //////////////////////////////

Pain: ++++++++++++++++



For Clinical Use Only

Allergies:

_____

_____

Height: _____

Weight: _____