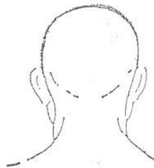
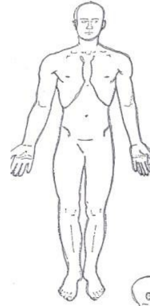
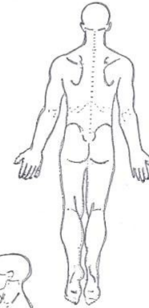
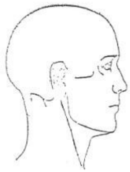
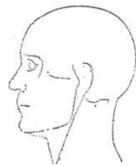
Morris Medical Center, P.A.

• Today's date:______________ •Name : ____

• Age____________• Date of Birth______________________• Height____________• Weight ____________

□Right hand dominant □ Left hand dominant •Sex: □Male □ Female

Chief Complaints;

• Current Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

• Average Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

• Location ____

____

____

____

• Does the pain radiate anywhere ("shooting down" or "shooting up")

____

• When was the pain started ? ____

____

• How was the pain started ?□ Work related □ Auto accident □ Athletic injury □ Injury at home
□ Other ____

- Please, describe your pain

□ Dull □ Aching □ Sharp □ Shooting □ Stabbing □ Throbbing□ Numbness □ Burning

____

____

- How often is your pain present ?□ Occasional □ Frequent □ Constant
- Worst time of day? □ Morning □ Afternoon □ Evening □ Night □All the time
- Any color change or temperature change? ____________________________
- Numbness anywhere? ____
- "Pins and needles" ? ____
- Weakness? (Right leg, right arm, both legs….) __________________________
- Swelling ? ____
- What makes symptoms worse/exacerbate? ______________________________

□ Walking □ Standing □ Lying down □ Sitting □ Bending forward □ Bending backward □ Driving
□ Coughing □ Bowel movement □ Cold weather □ Hot weather □ Rainy day □ Lifting objects

- What makes the symptoms better? ____

□ Resting□ Massage □ Exercise □ Sitting □ Lying down □ TENS unit □ Physical therapy
□ "Injections" □ Sleeping □ Medication (Names)________________□ Other ________________

- Sleeping : □ Well □ "OK" □ Terrible □ 2 hrs□ 4 hrs□ 6 hrs□ 8 hrs□>10 hrs
- How often do you wake up at night? □ 0□ 1 □ 2 □ 3 □ 4 □ >5 times
- Physical therapy□ Location__________________□ Date of Last PT____________□ Duration ____________
- TENS Unit□ Never used □ I have a unit □ I don't have one □ Used at home daily □ Used at home as needed □ Used during PT

Previous "injections"

	Date	Number of injection	Doctor's name
□ Epidural			
□ Facet			
□ Nerve block			
□ Joints			
□ Others			

Acupuncture ____________________ Psychotherapy ________________________

Chiropractor __________________ Other (Biofeedback, Meditation, Yoga, Swimming)

Review of System

- Gen ☐ Weight loss ☐ Weight gain ☐ Fever ☐ Fatigue ☐ Loss of appetite ☐ Nausea ☐ Vomiting
- Skin ☐ Skin problem ☐ Rash ☐ Psoriasis ☐ Slow healing ☐ Easy bruising ☐ Itching
- Neuro ☐ Light headed/dizziness ☐ Fainting ☐ Weakness☐ Stroke ☐ Tremor ☐ Seizure ☐ Memory loss
- Eyes ☐ Vision problem ☐ Glaucoma ☐ Blurred vision ☐ Double vision
- ENT ☐ Ear pain ☐ Hearing loss ☐ Ear noises ☐ Nose bleed ☐ Sore throat ☐ Hoarseness ☐ Dental problems
- Cardiovascular ☐ Chest pain ☐ Chest pressure ☐ Shortness of breath ☐ Irregular heart beat ☐ Murmurs
- Respiratory ☐ Coughing ☐ Difficulty breathing ☐ Asthma/Wheezing ☐Coughing up blood
- Gastrointestinal ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Bloody stool ☐ Pain in stomach ☐ Ulcers ☐ Hepatitis
- Genitourinary ☐ Painful urination ☐Frequent urination ☐ Bloody urine ☐ Kidney stone ☐ Incontinence ☐ Loss of libido ☐ Sexual difficulty ☐ Infection
- Endocrine ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Parathyroid problems
- Hematology ☐ Anemia ☐Bleeding disorder ☐ Easy bleeding ☐ Lymphoma/Leukemia ☐ Sickle cell disease
- Immunologic ☐ Catch cold easily ☐ HIV/AIDS ☐ Fever ☐ Hay fever ☐Frequent sinus problems ☐ Allergies
- Musculoskeletal ☐ Arthritis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Compression fracture ☐ Head injury ☐ Neck injury ☐ Lower back injury ☐ Spinal trauma ☐ Birth trauma ☐ Birth defect ☐ Lupus☐Spina bifida ☐ Gout ☐ Osteoporosis ☐ Muscular dystrophy ☐ Muscle pain ☐ Scoliosis
- Women only ☐ Irregular periods ☐Premenstrual depression ☐ Hot flashes ☐ Menstrual cramps ☐ Vaginal discharge ☐ Hysterectomy ☐ Breast surgery ☐ Nipple discharge ☐ Breast lumps ☐ Last mammogram ___________
- Men only ☐Burning on urination ☐ Dripping after urination ☐ Prostate problems ☐ Difficulty starting urination
- Psychiatric ☐ Depression ☐ Anxiety ☐ Panic attacks ☐ OCD ☐ Manic ☐ Bipolar ☐ Suicidal attempts ☐ Suicidal ideation ☐ Homicidal ☐Hallucination ☐ Psychosis ☐ Other _______________

Past Medical History

- Heart ☐ Coronary artery disease ☐ Hypertension ☐ Murmurs ☐Valvular disease ☐ Aneurysm ☐ High cholesterol ☐Pacemaker ☐ Deliberator ☐ Heart failure ☐ Angina ☐ Other _______________
- Lungs ☐Asthma ☐ COPD ☐ Emphysema ☐ Bronchitis ☐ TB ☐ Pneumonia ☐ Lung cancer ☐ Other __________
- Gastrointestinal ☐ Ulcer ☐ Reflux☐ Gastritis ☐ Hepatitis ☐ Cancer ☐ Bleeding ☐ Diverticulosis ☐ Other ______________
- Kidney ☐ Failure ☐ Stones☐ Dialysis (When)______________☐ Other _________________
- Endocrine ☐ Diabetes ☐ Hypothyrodism ☐ Hyperthyroidism ☐ Other _______________
- Neuro ☐ Stroke ☐ Aneurysm ☐ Brain cancer ☐ Nerve injury ☐ Spinal cord injury ☐ Alzheimer's ☐ Dementia ☐ Seizures ☐ Parkinson's ☐Other ___________
- Psychiatric ☐ Depression ☐Bipolar☐ Anxiety ☐ Panic disorder ☐ Psychosis ☐ Schizophrenia ☐Other ___________
- Bone/Muscular ☐ Arthritis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Gout ☐ Osteoporosis ☐ Scoliosis ☐ Other __________
- Cancer ☐ ____
- Other ☐ ____

Past Surgery History

____

____

Allergies

- Latex ☐ No ☐ Yes Reaction______________ • Contrast (Dye) ☐ No ☐ Yes Reaction _________
- Allergic to any medication(s) ?____

____

____

Current Medications

____

____

____

____

____

Significant Family History (Cancer, hypertension, diabetes, depression, back pain…)

- Father side ____
- Mother side ____
- Siblings ____

Social History

- Tobacco: ☐ Never ☐ Quit in________ ☐ Currently_____pack per day
- Alcohol : ☐ Never ☐ Rarely ☐ Moderate ☐ Daily_______________
- Use of drugs: ☐ Never ☐ Occasionally ☐ Frequently, Type/frequency _____________
- Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
- Family status: Living with ____
- Occupation: ____
- Disability: ☐ No ☐ Yes (Type) ______________________
- Litigation (Lawsuit): ☐ No ☐ Yes against_____________________working with ______________

Radiological studies / Lab studies

- MRI ☐ Neck__________ ☐ Upper back____________ ☐ Lower back_____________ ☐ Other ___________
  Date Date Date Date
- CT ☐ Neck__________ ☐ Upper back____________ ☐ Lower back_____________ ☐ Other ___________
  Date Date Date Date
- EMG ☐ Arm __________ ☐ Leg ____________ ☐ Other ________________