Riverview **Pain & Spine** Institute P.C.

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Office (609) 873-3005 Fax (201) 941-2869

Date:

____

First Name

Age

Referring Physician

Primary Physician Phone Number

Reason for the visit today:

Are you pregnant? YES NO Do you suspect you are pregnant? YES NO

Previous Treatment: PT Chiropractic Injections NSAID Treatment Pain Medication

Medical History: *Include any diseases, conditions, or incidents, chronic or temporary (Diabetes, heart attack etc...)*

Current Medications (May Attach a List):

Name	Dose	# Per Day	What do you take this medication for?

Plavix Clopidogrel Pradaxa Xarelto Trental Coumadin Fish Oil

Food/Medication Allergies (May Attach list):

Substance	Reaction

Contrast Dye Iodine Shellfish

Date: ___________________________

First Name Last Name Date of Birth

Surgical History:

Type of Surgery/Procedure	Dates

Pacemaker Defibrillator Number of Stents ________ Green Field Filter

Review of Systems:

Neurological:

Seizures	Yes	No
Strokes	Yes	No

Cardiovascular:

Chest Pain	Yes	No
Heart Attack	Yes	No
Irregular Heartbeat	Yes	No
High Blood Pressure	Yes	No
Anticoagulants	Yes	No
Murmur	Yes	No
Blood Clots	Yes	No

Ear, Nose, and Throat:

Nose Bleeds	Yes	No
Difficulty Swallowing	Yes	No
Cataracts/Glaucoma	Yes	No

Diabetes: Blood Sugar Values________

Insulin Use	Yes	No
Hepatitis	Yes	No

Gastrointestinal:

Ulcers	Yes	No
Reflux Disease	Yes	No

Respiratory:

Asthma	Yes	No
Emphysema	Yes	No
Tobacco Use	Yes	No
COPD	Yes	No

Bowel/Bladder:

Diarrhea	Yes	No
Constipation	Yes	No

Psychosocial:

Depression	Yes	No
Anxiety	Yes	No

Family History:

Condition	Mother(✓)	Father(✓)	Brother(✓)	Sister(✓)	Grandmother(✓)	Grandfather(✓)	Fatal (Yes/No)
Diabetes							

High Blood Pressure							
Liver Disease							
Thyroid Disease							
Cancer(s)							
Heart Disease							
Stroke							

Date: ______________________________________

____

First Name Last Name Date of Birth Age

Social History:

Marital Status:Single Married Divorced Separated Widowed

Number of Children: _________

Highest Level of Schooling: Eighth Grade High School Some College College

Trade School Masters Doctoral GED Diploma

Tobacco: Cigarettes/Day_________ Packs/Day_________ Alcohol Illicit Drug Use

Pain Assessment:

Please mark on the diagram the location of the pain

Current Pain Level: /10

1 2 3 4 5 6 7 8 9 10

Front Back Right Left

Worst Pain Level: /10

1 2 3 4 5 6 7 8 9 10

First and Last Initials: ______________

Check all that apply:

Aching Burning
Cramps Dull
Numbness Sharp
Shooting Stabbing
Stiffness Swelling
Throbbing Tingling

Other: (Please describe)

____

When did the pain begin? _______________________

____

	Yes	No	Date	Company/Legal Details
Is this pain a result of an auto accident?				

Have you had any PRIOR auto accidents?				
Is this pain a result of a work injury?				
Have you had any PRIOR work injuries?				
Is this pain a result of a personal injury accident?				
Have you had any PRIOR personal injury accidents?				

What brought the pain on?

____

The pain (is constant / comes and goes). If the pain comes and goes, how often does the pain occur? And for how long?

____

Does it interfere with (work / Sleep / Daily Routine / Recreation / Other: _______________)

Date: ________________________

____

First Name Last Name Date of Birth Age

Activities that are painful to perform: Sitting Standing Bending Other: ____________

None

When and what makes it better? ____

When and what makes it worse? ____

Any prior injuries to the area of pain? ____

Have you seen another healthcare practitioner for the pain/condition? (Yes/No)

If Yes, who? ____

Please Provide the Following Information:

Pharmacy Name: ____

Pharmacy Address: ____

Pharmacy Phone Number: ______________________________________

Patient Name: _______________________________________ Date: _______________________

Patient Signature: ___________________________________

Physician's Notes:

Physical Exam:

Height: ______ Weight: ______ Age: _______ Vitals: ___________ P ___________ R __________ T__________

Clinical Notes:

____
____
____
____
____
____
____

Imaging Studies: **CT scan** **MRI** **EMG** **Bone Scan** **X-Ray**

Treatment Plan: **ESI** **R** **Facets** **B/L** **Surgical Consult** **Other**_______________

L **R** **Physical Therapy**

L

Tens Unit **Compound Pain Cream** **Orthotics**

Physician's Signature: ____ **Date:** ________________________