*****PLEASE PRINT NAME AND DATE OF BIRTH ON THE TOP OF EACH FOLLOWING PAGE*****

Patient Name: ________________________ ______________________________
(First) (Last)

Social Security Number: _____________________ Date of Birth: ________________________
(mm/dd/yyyy)

Gender: ☐ Male
☐ Female

Marital Status: ☐ Unmarried
☐ Married
☐ Single
☐ Widowed
☐ Divorced

Ethnicity: ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific
☐ Other Race
☐ White

Language: ☐ English
☐ Other ________________

Hand Dominance (*choose one*):
☐ Ambidextrous
☐ Left Hand Dominant
☐ Right Hand Dominant

Communication Preference (*choose one*): ☐ Phone
☐ Cell Phone

Address: ___________________________________
____
City: ____________________ State: __________
Zip: ____________________

Phone: _______________________
Cell: _________________________
Work Phone: __________________

Patient Employer: ____

Advanced Directive (Living Will): Do you have an Advanced Directive?
Check yes only if you can provide us a copy today. ☐Yes / ☐No

Emergency Contact

Name: ____________________________________ Home Phone: ___________________
Relationship:_______________________________ Cell Phone: __________________

Pharmacy: ____
Pharmacy Phone: ____

Patient Name:______________________________ DOB:____

Referring Doctor: ____

Primary Care Physician: ____

Patient's Primary Insurance Plan: ____

Is your insurance a benefit provided directly to you or through a spouse, parent, or other person?

 Self
 Spouse
 Parent
 Other

Please list Name if other than self: ____
Please list Birth Date if other than self: ____
(mm/dd/yyyy)
Please list Social Security Number if other than self: _____________________________
Please list Address if other than self:

Address: ____
City: ______________________ State: ___________
Zip: ______________________

Please list Phone if other than self: _________________________________

CHIEF COMPLAINT: (*Give a brief description of the nature of your visit – for example, left knee pain*)
____
____

Please describe how your injury occurred: ____
____
____
____
____

Have you ever had this problem in the past? No Yes

Were you seen in the Emergency Room for your complaint?
No Yes , Date: _________________
Were x-rays taken? No Yes
Were medications prescribed? No Yes
Name of medications: ____

Did another physician treat you for your complaint?
No Yes , Physician: ______________________________ Date: _________________

Have you seen a Pain Management physician? No Yes

Have you had prior diagnostic studies for your complaint?
No Yes , CAT Scan / X-Ray / Bone Scan / MRI / EMG

Where? _______________________________ Date: _________________

Patient Name:_____________________________ DOB:____

REVIEW OF SYSTEMS

****PLEASE **ONLY** MARK **YES** TO PROBLEMS YOU ARE **CURRENTLY** HAVING****

CARDIOVASCULAR
- ☐ Bleeding Problems
- ☐ Chest Pain
- ☐ Circulation Problems
- ☐ Palpitations
- ☐ Other: _____________

CONSTITUTIONAL
- ☐ Fatigue/Weakness
- ☐ Itching
- ☐ Skin Problems
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other: _____________

E.N.T.
- ☐ Ear Discharge
- ☐ Hearing Loss
- ☐ Nosebleeds
- ☐ Runny Nose
- ☐ Sore Throat
- ☐ Other: _____________

ENDOCRINE
- ☐ Cold Intolerance
- ☐ Fatigue
- ☐ Heat Intolerance
- ☐ Hot Flashes
- ☐ Other: _____________

EYES
- ☐ Blurred Vision
- ☐ Eye Pain
- ☐ Failing Vision
- ☐ Vision Loss
- ☐ Other: _____________

GASTROINTESTINAL
- ☐ Abdominal
- ☐ Appetite Loss
- ☐ Blood in Stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ GI Bleed
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Other: _____________

GENITOURINARY
- ☐ Difficult Urination
- ☐ Excess Urination
- ☐ Frequent Urination (PM)
- ☐ Leakage of Urine
- ☐ Painful Urination
- ☐ Passing Stones
- ☐ Pregnancy
- ☐ Retention of Urine
- ☐ Other: _____________

MUSCULOSKELETAL
- ☐ Ankle Swelling
- ☐ Disturbance in Walking
- ☐ Extremity Numbness
- ☐ Extremity Pain
- ☐ Extremity Weakness
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Neck Pain
- ☐ Numbness
- ☐ Stiffness
- ☐ Tingling Sensation
- ☐ Other: _____________

NEUROLOGICAL
- ☐ Difficulty Walking
- ☐ Dizzy Spells
- ☐ Memory Loss
- ☐ Severe Headaches
- ☐ Weakness
- ☐ Other: _____________

PSYCHIATRIC
- ☐ Anxious
- ☐ Depressive state
- ☐ Memory Loss
- ☐ Other: _____________

RESPIRATORY
- ☐ Chest Pain
- ☐ Chronic Coughing
- ☐ Difficulty Breathing
- ☐ Shortness of Breath
- ☐ Other: _____________

ALLERGIES TO MEDICATIONS/FOODS

Name of Medication/Food	Reaction
☐**NONE**	
1.________________________	☐Chest pain ☐Breathing Difficulties ☐Headaches ☐Hives ☐Itching ☐Nausea ☐Throat tightness ☐Muscle/Joint Pain ☐Other ____________
2.________________________	☐Chest pain ☐Breathing Difficulties ☐Headaches ☐Hives ☐Itching ☐Nausea ☐Throat tightness ☐Muscle/Joint Pain ☐Other ____________
3.________________________	☐Chest pain ☐Breathing Difficulties ☐Headaches ☐Hives ☐Itching ☐Nausea ☐Throat tightness ☐Muscle/Joint Pain ☐Other ____________
4.________________________	☐Chest pain ☐Breathing Difficulties ☐Headaches ☐Hives ☐Itching ☐Nausea ☐Throat tightness ☐Muscle/Joint Pain ☐Other ____________
5.________________________	☐Chest pain ☐Breathing Difficulties ☐Headaches ☐Hives ☐Itching ☐Nausea ☐Throat tightness ☐Muscle/Joint Pain ☐Other ____________
6.________________________	☐Chest pain ☐Breathing Difficulties ☐Headaches ☐Hives ☐Itching ☐Nausea ☐Throat tightness ☐Muscle/Joint Pain ☐Other ____________
7.________________________	☐Chest pain ☐Breathing Difficulties ☐Headaches ☐Hives ☐Itching ☐Nausea ☐Throat tightness ☐Muscle/Joint Pain ☐Other ____________

Patient Name:______________________________ DOB:____

FAMILY MEDICAL HISTORY

(*Check problem and indicate who was diagnosed: Mother= M, Father = F, Sibling = S, Grandparent = G)*

☐ Adopted

Disorder	**Who**			
☐ Alcohol Liver Disease………………	☐M	☐F	☐S	☐G
☐ Bleeding Disorder…………………..	☐M	☐F	☐S	☐G
☐ Mental Disorder……………………..	☐M	☐F	☐S	☐G
☐ Diabetes…….. 1……2……………..	☐M	☐F	☐S	☐G
☐ GERD………………………………	☐M	☐F	☐S	☐G
☐ Heart Disease………………………	☐M	☐F	☐S	☐G
☐ Stroke………………………………	☐M	☐F	☐S	☐G
☐ Anesthetic Complications…………..	☐M	☐F	☐S	☐G
☐ Rheumatoid Arthritis………………..	☐M	☐F	☐S	☐G
☐ Osteoarthritis………………………..	☐M	☐F	☐S	☐G
☐Lupus…………………………………	☐M	☐F	☐S	☐G

☐ Cancer

Type: ___________________	☐M	☐F	☐S	☐G
Type: ___________________	☐M	☐F	☐S	☐G
Type: ___________________	☐M	☐F	☐S	☐G
Type: ___________________	☐M	☐F	☐S	☐G
Type: ___________________	☐M	☐F	☐S	☐G

PAST SURGICAL HISTORY (*Please print*)

☐ NO PAST OPERATIONS

General Surgery

- ☐ AAA Repair (year:___________)
- ☐ AICD (year:_________)
- ☐ Appendectomy (year:_________)
- ☐ Breast Surgery (year:_________)
- ☐ CABG (year:_________)
- ☐ Caesarean Section (year:______________)
- ☐ Carotid Endarterectomy (year:__________)
- ☐ Cataract Extraction (year:______)
- ☐ Cholecystectomy (year:________)
- ☐ Colon Resection (year:________)
- ☐ Defibrillator Implant (year:____________)
- ☐ Fundoplication (year:_________)
- ☐ Gall Bladder (year:___________)
- ☐ Gastric Bypass (year:_________________)
- ☐ Heart Procedure/Surgery (year:_________)
- ☐ Hernia (year:________________)
- ☐ Hysterectomy (year:___________)
- ☐ Lung Surgery (year:___________)
- ☐ Pacemaker (year:_____________)
- ☐ Prostate Surgery (year:________)
- ☐ Tonsillectomy (year:__________)
- ☐ Tubal Ligation (year:__________)
- ☐ Other:______________________________
____

Orthopedic Surgery

- ☐ Arthroscopy (year:___________)
- ☐ Ankle ☐Lt / ☐Rt (year:______________)
- ☐ Elbow ☐Lt / ☐Rt (year:______________)
- ☐ Hand ☐Lt / ☐Rt (year:______________)
- ☐ Fingers ☐Lt / ☐Rt (year:______________)
- ☐ Hip ☐Lt / ☐Rt (year:______________)
- ☐ Knee ☐Lt / ☐Rt (year:______________)
- ☐ Shoulder ☐Lt / ☐Rt (year:_____________)
- ☐ Wrist ☐Lt / ☐Rt (year:______________)
- ☐ Ankle Replacement ☐Lt / ☐Rt (year:________)
- ☐ Carpal Tunnel Release ☐Lt / ☐Rt (year:________)
- ☐ Hip Replacement ☐Lt / ☐Rt (year:________)
- ☐ Knee Replacement ☐Lt / ☐Rt (year:________)
- ☐ Shoulder Replace. ☐Lt / ☐Rt (year:________)
- ☐ Back Surgery ☐Cervical ☐Thoracic ☐Lumbar (year:__________)
- ☐ Implants/Hardware (pins, rods, screws, plate): which body part: ______________________________

Patient Name:______________________________ DOB:____

PAST MEDICAL HISTORY

- ☐**Abdominal Problems:**
  - ☐ Gastritis
  - ☐ Gallstones
  - ☐ Hernia
  - ☐ GERD/Acid reflux/Heartburn
  - ☐ Diverticulosis
  - ☐ Irritable Bowel Synd.
  - ☐ Colitis
  - ☐ Colostomy / Ileostomy
  - ☐ Obesity
- ☐**Anesthesia Complication**
- ☐**Blood Bourne Pathogen Exposure**
- ☐**Blood Disorders:**
  - ☐ Sickle Cell Anemia
  - ☐ Anemia
  - ☐ Polycythemia
- ☐**Cancer:** (describe)

  ____

  - ☐ Chemo
  - ☐ Radiation
  - ☐ Surgery
- ☐**Circulation/ Vascular Problems:**
  - ☐ Blood Clots/DVT
  - ☐ Peripheral Artery Disease
  - ☐ Varicose Veins
  - ☐ Stroke/ TIA
  - ☐ Phlebitis
  - ☐ Aneurysm
- ☐**Diabetes: ☐Type 1, ☐Type 2**
- ☐**Ear / Nose / Throat Problems:**
  - ☐ Deafness / Hearing Problems
  - ☐ Meniere Disease
  - ☐ Deviated Septum
  - ☐ Sinus infections
  - ☐ TMJ Problems
  - ☐ Thyroid High Low
  - ☐ _________________
- ☐**Edema**
- ☐**Eye**
  - ☐ Cataracts
  - ☐ Glaucoma
  - ☐ Blindness
  - ☐ Poor / Failing Vision
  - ☐ Macular Degeneration
- ☐**Gout**
- ☐**Heart Disease:**

  Cardiologist:
  DR.____________________

  - ☐ Mitral Valve Prolapse
  - ☐ MI / Heart Attack
  - ☐ Coronary Artery Disease
  - ☐ Arrhythmia
  - ☐ Pacemaker / Defibrillator
  - ☐ Murmur
  - ☐ CHF / Congestive Heart Failure
  - ☐ Congenital Disease
- ☐**Hypertension-**high blood pressure
- ☐**Hypercholesterolemia**
- ☐**Infections:**
  - ☐ Bone / Joint
  - ☐ MRSA / Staph.
  - ☐ HIV – AIDS
  - ☐ Herpes
  - ☐ TB (Tuberculosis)
  - ☐ Lyme Disease
  - ☐ Rheumatic Fever
- ☐**Insomnia**
- ☐**Kidney / Urinary / Reproductive:**
  - ☐ Stones
  - ☐ Failure: ☐Dialysis ☐No Dialysis
  - ☐ Currently Pregnant
  - ☐ Prostate: ☐Cancer ☐Enlargement
  - ☐ Renal Transplant
- ☐**Liver Disease:**
  - ☐ Hepatitis: ☐ A ☐B ☐C ☐Unknown
  - ☐ Jaundice
  - ☐ Cirrhosis
  - ☐ Failure
  - ☐ Liver Transplant
- ☐**Lung Disease:**
  - ☐ Asthma
  - ☐ COPD
  - ☐ Emphysema
  - ☐ Sleep Apnea: CPAP ☐Yes ☐No ☐Doesn't use
  - ☐ TB exposure
- ☐**Lupus**
- ☐**Neuro / Spine Problems:**
  - ☐ Degenerative Disc Disease ☐Cervical ☐Thoracic ☐Lumbar
  - ☐ Spinal stenosis
  - ☐ Scoliosis
  - ☐ Herniated Disc
  - ☐ Coccydynia (Tailbone Pain)
  - ☐ Neuropathy
  - ☐ MS (Multiple Sclerosis)
  - ☐ Alzheimer's
  - ☐ Parkinson's
  - ☐ Seizures
  - ☐ Myasthenia Gravis
  - ☐ Headaches
  - ☐ Vertigo
- **Orthopedic / Arthritis / Rheumatology**:
  - ☐ Fractures**:** (describe)

    ____
  - ☐ Laceration:_______________
  - ☐ Upper Extremity Diagnosis:
    - ☐Carpal tunnel syndrome
    - ☐Impingement
    - ☐Tendon / Ligament Tear
    - ☐Sprain / Strains

    ____
  - ☐ Lower Extremity Diagnosis
    - ☐Meniscal Tear
    - ☐ACL Tear
    - ☐Bursitis
    - ☐Sprains / Strains

    ____
  - ☐ Osteoarthritis
  - ☐ Rheumatoid Arthritis
  - ☐ Degenerative Joint Disease
  - ☐ Polymyalgia
  - ☐ Fibromyalgia
- ☐**Osteoporosis / Osteopenia**
- ☐**Psychiatric:**
  - ☐ Depression
  - ☐ Anxiety
  - ☐ Bi-Polar
  - ☐ ADD / ADHD
  - ☐ Panic Attacks
  - ☐ Claustrophobia
  - ☐ Schizophrenia
  - ☐ PTSD
- ☐**Skin Disorders:**
  - ☐ Acne
  - ☐ Psoriasis
  - ☐ Rosacea
  - ☐ Vitiligo

Patient Name:______________________________ DOB:____

SOCIAL HISTORY

Do you smoke? Yes Quit Never
If the answer is YES or QUIT,
When did you quit? ___________
Maximum number of packs per day? ___________
Total number of years? ___________

Do you chew tobacco? Yes Quit Never
If the answer is YES or QUIT,
When did you quit? ___________
Maximum amount per day? ___________
Total number of years? ___________

Do you drink alcohol *(including beer or wine)*? No Yes , Number of drinks per week? _____
Type of alcohol? ______________
Are you a recovering alcoholic? No Yes

Marital status: Single Married Widowed Divorced

OCCUPATION: Working title: ___________________________ Are you retired? No Yes *If retired, please list pre-retirement occupation:* _______________________________________

Name of employer: ______________________________________

Job position: ____ Full Time: No Yes / Part Time: No Yes

Length of time in this position: ____________ Length of time at this company: ____________

Is this complaint related to a:

Workers' Compensation claim? No Yes, **DATE OF INJURY**: _________________

Motor Vehicle Accident? No Yes, **LAST DATE WORKED**: _____________

Personal Injury? No Yes

Is there an attorney involved? No Not yet Yes

Name of attorney: ____

Patient Name:_______________________________ DOB:____

CURRENT MEDICATIONS (Including over-the-counter medications)

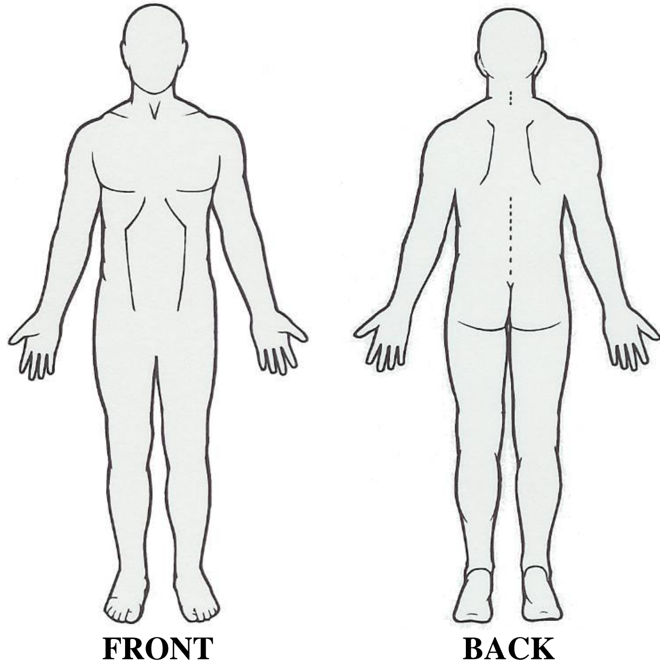
(*Please print*)

☐ **NOT CURRENTLY TAKING ANY MEDICATIONS**

	Name of Drug:	Dosage:	Frequency: How Long have you taken this medication?	This medication has helped: *A lot*	*Some*	*None*
1.				☐	☐	☐
2.				☐	☐	☐
3.				☐	☐	☐
4.				☐	☐	☐
5.				☐	☐	☐
6.				☐	☐	☐
7.				☐	☐	☐
8.				☐	☐	☐
9.				☐	☐	☐
10.				☐	☐	☐
11.				☐	☐	☐
12.				☐	☐	☐
13.				☐	☐	☐
14.				☐	☐	☐
15.				☐	☐	☐
16.				☐	☐	☐
17.				☐	☐	☐
18.				☐	☐	☐
19.				☐	☐	☐
20.				☐	☐	☐

Patient Name:______________________________ DOB:____

Using the diagram below, mark your area(s) of pain:



DESCRIBE YOUR PAIN:

Severity: Mild Moderate Severe

Quality: Dull Sharp Aching Throbbing

Duration: Intermittent Constant Night Day

Made better by: ____

Made worse by: ____

DAILY ACTIVITIES

Activity	Able	Not Able	Explanation
Dressing Self			
Personal Hygiene			
Household Cleaning			
Grocery Shopping			
Read			
Manage Own Money			
Laundry			
Eating			
Cooking			
Driving			
Watching Television			
Use Computer			
Part-Time Work			

I HAVE:

- ☐ Neck Pain Only
- ☐ Neck Pain and Arm Pain
- ☐ Upper Back Pain (Thoracic)
- ☐ Low Back Pain Only
- ☐ Low Back and Leg Pain
- ☐ Scoliosis

I HAVE HAD THIS PROBLEM FOR:

_________ Days

_________ Weeks

_________ Months

_________ Years