

MEDICAL INFORMATION

TODAY'S DATE: _____ SOCIAL SECURITY NUMBER: _____

PATIENT NAME: _____ BIRTHDAY: _____

HEIGHT: _____ WEIGHT: _____ AGE: _____

WHO REFERRED YOU? _____ RACE: _____

PRIMARY CARE PHYSICIAN: _____ SEX: _____

DOCTOR'S ADDRESS: _____

SECTION 1: Chief Complaint- Check all that may apply

<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Wrist Pain	Right	Left	Both
<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	Elbow Pain	Right	Left	Both
<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	Shoulder Pain	Right	Left	Both
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Foot Pain	Right	Left	Both
<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Ankle Pain	Right	Left	Both
<input type="checkbox"/>	Headache	<input type="checkbox"/>	Knee Pain	Right	Left	Both
<input type="checkbox"/>	Face Pain	<input type="checkbox"/>	Hip Pain	Right	Left	Both
<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	Other _____			

How long have you had this pain? _____ (circle) days weeks months years

SECTION 2: Pharmacy Information

Pharmacy Name and Address: _____

Pharmacy Phone Number: _____

SECTION 3: Allergies

List all allergies to MEDICATIONS

SECTION 4: Medications

What you are currently taking and HOW MANY in an average day

SECTION 5: Family History

Family History: CANCER – check any that apply							
Cancer	Mother	Father	Brother	Sister	Son	Daughter	No FHx
Brain							
Breast							
Cervical							
Colon							
GI							
Kidney							
Lung							
Ovarian							
Prostate							
Skin							
Testicular							
Thyroid							

Family History: General – check any that apply							
Disease	Mother	Father	Brother	Sister	Son	Daughter	No FHx
Alcoholism							
Addiction							
Anemia							
Autoimmune							
Diabetes							
Heart Disease							
Hypertension							
Lung Disease							
Mental Illness							
Migraine							
Heart Attack							
Kidney Failure							
Seizures							
Stroke							
Thyroid Disease							
Tuberculosis							

SECTION 6: Social History

Tobacco Use (including dip, e-cigs, vapor, cigars): Current Former Never

Tobacco-years of use: _____

How much do you smoke (i.e., 1 pack per day)? _____

Are you attempting to quit smoking? Yes No Not Applicable

If you are a former smoker, when did you quit? _____

Do you drink alcohol? Yes No How much? _____ per week/month/year

Do you use any illicit drugs? Yes No What? _____

Marital Status (circle): Single Married Widowed Divorced Separated

Number of Children: _____

Work Status: Full Time Part Time Retired On Disability Applying for Disability
Unemployed

Auto related injury? Yes No

Work related injury? Yes No

Legal Situation: Yes No PENDING

Usual Activity Level: None Limited Moderate Active Very Active

If your problem is not the result of an accident or injury, proceed to the next section.

Injury date: _____ (put specific date if known)

Were you taken off work after your injury? ____ Yes ____ No

If yes, for how long? _____ (give dates if you know them)

Describe briefly the circumstances surrounding the accident or injury - if applicable

SECTION 7: Past Surgical History

Please check all the operations you have had:

<input type="checkbox"/> Heart bypass	<input type="checkbox"/> Knee
<input type="checkbox"/> Heart stents	<input type="checkbox"/> Hip
<input type="checkbox"/> Carotid Artery	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Low back	<input type="checkbox"/> Rotator Cuff
<input type="checkbox"/> Neck	<input type="checkbox"/> Ankle
<input type="checkbox"/> Mid back	<input type="checkbox"/> Wrist
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Carpal Tunnel
<input type="checkbox"/> Appendix	<input type="checkbox"/>
<input type="checkbox"/> Tonsils or Adenoids	<input type="checkbox"/>
<input type="checkbox"/> Ear tubes	<input type="checkbox"/>
<input type="checkbox"/> Inguinal Hernia	<input type="checkbox"/>
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/>
<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/>
<input type="checkbox"/> C-section	<input type="checkbox"/>
<input type="checkbox"/> Breast	<input type="checkbox"/>

List all other operations

SECTION 8: Past Medical History

Please check all that apply:

<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	Heart Attack (MI)	<input type="checkbox"/>	Prostate Cancer
<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	Heart Disease (CAD)	<input type="checkbox"/>	Prostate Disease
<input type="checkbox"/>	Addiction/Alcoholism	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Psychiatric/Mental Health
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Heart Valve Disease	<input type="checkbox"/>	Seasonal Allergies
<input type="checkbox"/>	Anxiety Disorder	<input type="checkbox"/>	Heavy Snoring	<input type="checkbox"/>	Seizures/Epilepsy
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Sickel Cell
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Sleep Apnea
<input type="checkbox"/>	Atrial fibrillation	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	Stomach Ulcers
<input type="checkbox"/>	Back Injury	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Stroke/TIA
<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Substance Abuse
<input type="checkbox"/>	COPD/Emphysema	<input type="checkbox"/>	Hypotestosteronism	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Chron's disease	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	Ulcerative Colitis
<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Vision or Eye Problems
<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	Liver Disease	Please List Any Other Problems	
<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Multiple Sclerosis		
<input type="checkbox"/>	Decreased Hearing	<input type="checkbox"/>	Muscle Weakness		
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Muscular Disease		
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Neck Stiffness		
<input type="checkbox"/>	Easy bruising/bleeding	<input type="checkbox"/>	Osteoporosis		
<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Pacemaker		
<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Pancreatitis		
<input type="checkbox"/>	GERD/Acid Reflux	<input type="checkbox"/>	Pneumonia		
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Poor Circulation		
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Possibility of Pregnancy		
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Productive Cough		

SECTION 9: Pain History

What does your pain feel like (circle all that apply)? Sharp Stabbing Shooting Dull Aching Pressure
Burning Tingling Other: _____

Does it go anywhere else? _____

What time of day is it worst (circle one)? Morning Midday Evening Constant

What makes your pain worse? _____

What makes your pain better? _____

Do you have any of the following associated with your pain (circle all that apply)?

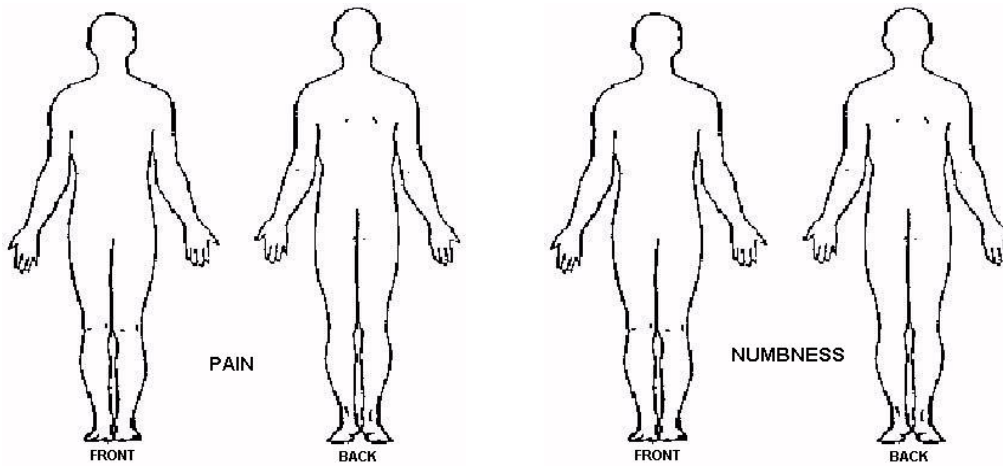
Trouble controlling your bladder Trouble controlling your bowels
Difficulty sleeping Anxiety Depression Feeling Tired

What is your pain score? Current: ____/10 Best: ____/10 Worst: ____/10

Have you tried the following treatments for your pain?

Physical Therapy:	Yes	No
Chiropractor:	Yes	No
Pain Medications:	Yes	No
Steroids:	Yes	No
TENS/muscle stimulator:	Yes	No
Heat/Ice:	Yes	No
Surgery:	Yes	No
Pain Procedures (Epidurals, Nerve blocks, etc.):	Yes	No

Please shade the painful and numb areas in the diagrams below:



SECTION 10: Other medical complaints

Check all that you FREQUENTLY have

<input type="checkbox"/> Fever	<input type="checkbox"/> Pounding Heart Beat	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rash	<input type="checkbox"/> Suicidal Thoughts
<input type="checkbox"/> Weight Changes	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Laceration	<input type="checkbox"/> Drug Dependency
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cough	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Increased Thirst
<input type="checkbox"/> Chills	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Weakness	<input type="checkbox"/> Cold Intolerance
<input type="checkbox"/> Appetite Changes	<input type="checkbox"/> Coughing up blood/sputum	<input type="checkbox"/> Numbness	<input type="checkbox"/> Increased Hunger
<input type="checkbox"/> Vision Changes	<input type="checkbox"/> Nausea	<input type="checkbox"/> Seizures	<input type="checkbox"/> Heat Intolerance
<input type="checkbox"/> Hearing Changes	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Swollen Glands
<input type="checkbox"/> Nose Problems	<input type="checkbox"/> Constipation	<input type="checkbox"/> Migraines	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Headaches	<input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Tremor	<input type="checkbox"/> Runny Nose
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Depression	<input type="checkbox"/> Sinus Pressure
<input type="checkbox"/> Shortness of Breath (SOB)	<input type="checkbox"/> Difficulty Urinating	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Itching
<input type="checkbox"/> SOB when walking	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Addiction	<input type="checkbox"/> Hives
<input type="checkbox"/> SOB when lying down	<input type="checkbox"/> Urinary Frequency	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Frequent Sneezing

Any other pertinent information you think we need to know.