OFFICE USE ONLY

Patient Name: ______________________________

MR #: _____________________________________

Primary Care Doctor: ______________________________ **Referring Doctor:** ______________________________

Was your injury a result of a: Motor Vehicle Accident Work Related Injury **Date of injury:** ___________

Which side of body is injured/hurt: Right Left **Describe your illness/injury:** __________________________

____

Have you seen another doctor for this? Yes **If yes, who?** ____

Have any x-rays or studies been done on the injured body part? Yes **If yes, where?** __________________

Occupation: ______________________________________

Pain rating scale: (click one)

Mild 1-3 Moderate 4-6 Severe 7-10

Patient Medical History (please click any that apply to you)

High Blood Pressure Shortness of Breath Ulcers Heart Disease Diabetes Kidney Disease Cough Stroke Arthritis Asthma Blood Clots Epilepsy/Seizures Thyroid Disease Constipation Diarrhea Congestive Heart Failure Blood Disorders Coronary Artery Disease Indigestion Hepatitis Lung Problems COPD High Cholesterol Cancer (type) _________________Other ___________________

Allergies: Penicillin Morphine Codeine Darvon Darvocet Sulfa Iodine Tape
Other ____ Food: ____

Medications (currently taking):

Drug Name	Dosage	Drug Name	Dosage

Previous Surgeries:

Surgery	Date	Surgery	Date

Do you use: Tobacco Alcohol Drugs

Marital status:

Number of children: ____________________

Occupation: ____________________________

Family Medical History (please click any that apply)

High Blood Pressure Ulcers Heart Disease Diabetes Kidney Disease Stroke Arthritis Asthma Blood Clots Epilepsy/Seizures Thyroid Disease Congestive Heart Failure Blood Disorders Coronary Artery Disease Indigestion Hepatitis Lung Problems COPD High Cholesterol Cancer (type) _________________Other ___________________

TO BE COMPLETED BY BACK PATIENTS ONLY

When (roughly what date) did your present pain start?

____

Are you still working? ___Yes ___No
Last day on job_____________________________

How did pain start? (check appropriate boxes)

☒ Suddenly	☒ Pulling
☒ Gradually	☒ Injured at work
☒ Lifting	☒ Injured in auto accident
☒ Twisting	☒ Hit from behind
☒ Fall	☒ Injured during sports
☒ Bending	☒ No apparent cause

What activities make the pain worse?

☒ Exercise (during)	☒ Bending forward
☒ Exercise (after)	☒ Bending backward
☒ Sitting	☒ Coughing
☒ Standing	☒ Sneezing
☒ Walking	

What reduces the pain?

☒ Lying down	☒ Pain pills
☒ Sitting	☒ Injections for pain
☒ Standing	☒ Muscle relaxant pills
☒ Walking	☒ Aspirin / anti inflammatories
☒ Manipulation	☒ Nothing
☒ Exercises	☒ Other__________________

How long have you had this pain?
____ years _____months ____weeks

Give the date of any diagnostic studies

______X-rays ________CT _______Myleogram

_____Electromyogram ________Discogram

______MRI ______Arthrogram ______Injections

Patient/Responsible Party Signature:

____

Have you been hospitalized for your pain problems?

____No _____Yes (dates)____________

Do you want a report sent to your attorney?

____Yes ____No ____Have no attorney

Any additional information that would be helpful in understanding your problem _______________

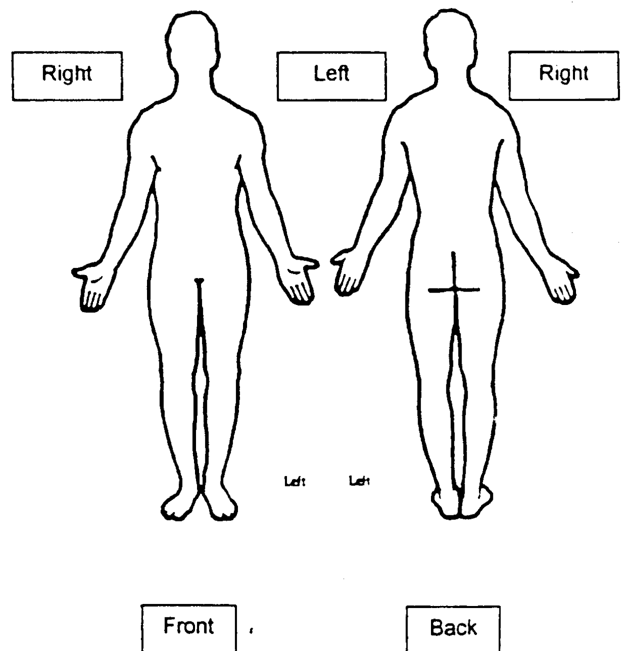
____

____

Mark the areas of your body where you fell the sensations described below, using he appropriate symbols

■ Aching = Numbness O Pins & Needles

X Burning / Stabbing



1-3	4-6	7-10
Mild	Moderate	Severe