Name: _____ **Date of Birth:**_____ **Age:**_____

Doctor who referred you:_____

Primary Care Doctor: _____

E-mail: _____ (used ONLY for appt reminders and Health Record Access enrollment)

Ethnicity: _____ (For example, Hispanic)

Preferred Language: _____

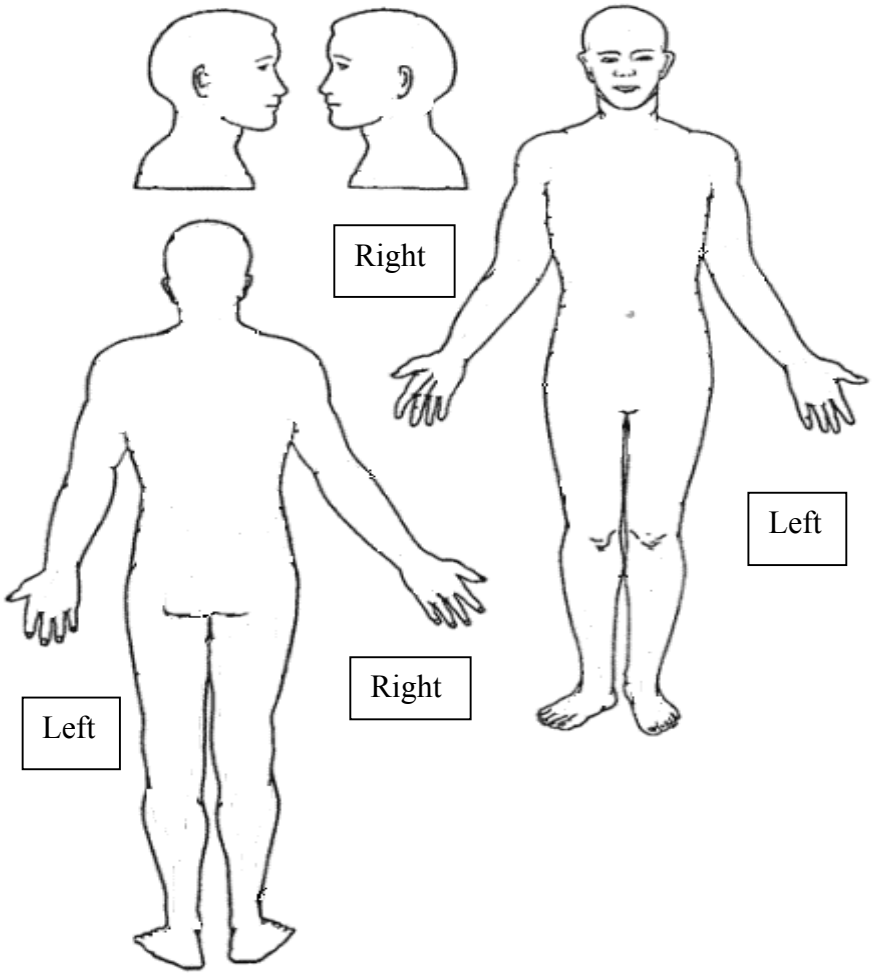
Race: ___ Caucasian ___ Latino ___ African-American ___ Asian ___ Other:_____

Height: _____**ft** _____**in** **Weight:** _____

Using the symbols below, mark the area on your body where you feel the described sensations.

>>>>> Numbness **XXX** Burning ^^^^^ Other Pain

000000 Pins and Needles **!!!!!!!!!** Stabbing ●●● Aching



What was your date of injury?

_____

How long have you had this pain?

_____years _____months

What were you doing when it started?

_____

On scale of 1 to 10, how would you rate your pain (10 is highest level of pain)?

_____

What kind of **TREATMENT** have you had for THIS CURRENT EPISODE of pain?

	YES	NO		YES	NO
Bed rest/ Activity Modification			Brace		
Medications			Massage Therapy		
Physical Therapy			Injections (cortisone)		
Heat or Cold Therapy			Other Treatments		
Chiropractor					
Acupuncture					

	YES	NO
Do you have difficulty with balance when you are walking?		
Have you had difficulty with handwriting?		
Do you have difficulty with buttons and zippers?		
Do you have neck pain?		
Does flexing or extending your neck make your symptoms worse?		
If you have low back pain, is it worsened with activity?		
If you have leg pain, is it worsened with activity?		
Are your symptoms improved by leaning forward?		
Have you had any changes to your bowel or bladder habits?		

	YES	NO
Have you missed work because of this problem?		
Is this problem the result of a work-related injury?		
Is this problem the result of a motor vehicle accident?		
Is there a lawyer involved?		

ILLNESSES/INJURIES/ SURGERIES

Date:	Illness, Injury, or Surgery:

PAST MEDICAL HISTORY

Disorder	Yes	No	Disorder	Yes	No
Anxiety/Depression			Asthma		
Nervous Breakdown			Pneumonia		
Any Psychiatric Disorder			Emphysema		
Heart Attack			Chronic Bronchitis		
Angina (Chest Pain)			Pulmonary Embolism		
Congestive Heart Failure			Hepatitis, HIV, or AIDS		
High Blood Pressure			Diabetes Mellitus		
Bleeding Disorders			Cancer		
Kidney Failure			Recurrent Infections		

ALLERGIES TO MEDICATIONS □**Yes** or □**No?** (Please circle one, if Yes please list drugs and reactions. If this area is left blank it will be assumed that there are no known drug allergies.)

Medication	**Reaction to this Medication**
Do you have a Latex Allergy? □Yes or **□No?**	

FAMILY MEMBERS with medical problems? (cancer, diabetes, etc.)

Disorder	**Family Member(s)**

SOCIAL HISTORY	**Yes**	**No**
Alcohol Use		
Smoking		

MEDICATIONS YOU ARE TAKING:

Name of medication	**Dose**	**Name of Medication**	**Dose**

ROS: Place an 'X' if you NOW have or RECENTLY have had:

General		Skipped beats		**Musculoskeletal**	
Fever		**Hematologic/ Lymph**		Leg cramps in the calf	
Chills		Easy bleeding		Joint pain	
Difficulty sleeping		Easy bruising		Fibromyalgia	
Feeling tired		Swollen glands-- neck		Decrease in strength	
Head/ Eyes		**Lungs**		**Skin**	
Eyesight problems		Shortness of breath		Skin lesions	
Headaches		Cough		Rashes	
Hearing loss		Wheezing		**Psychiatric**	
Nose/ Mouth/ Throat		Coughing up blood		Depression	
Nosebleeds		**Gastrointestinal**		Anxiety	
Mouth sores		Heartburn		Tremor	
Throat Pain		Abdominal pain		Fainting	
Recent weight loss		Diarrhea/ Constipation		**Other**	
Heart		**Genitourinary**		Decrease in appetite	
Mitral Valve Prolapse		Incontinence		Intolerance to heat	
Chest pain		Urinary frequency		Intolerance to cold	
Palpitations		Uncontrollable bowels		Motor Disturbances	
Swollen ankles/ feet		Irritable Bowel Syndrome		Sensory Disturbances	