

**Today's Date**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Referring Physician** \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_

**First Name:** \_\_\_\_\_ **Last:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **Physical Address** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone#:** \_\_\_\_\_ **Cell#:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Marital Status**   **M**   **S**   **other** **Social Security#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Present Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_ **Work Phone #:** \_\_\_\_\_

**Name of Emergency Contact:** \_\_\_\_\_ **Emergency Contact#:** \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

<b>Who is responsible for this account? (Self, Insurance, W.C., Attorney)</b> _____	
<b>Is litigation involved? YES or NO</b>	<b>Claim/Policy #:</b> _____
<b>Ins:</b> _____	<b>Insured Name:</b> _____
<b>Relationship to Insured:</b> _____	<b>Insured DOB:</b> ____/____/____
	<b>Insured SS#:</b> _____

**Date last worked:** \_\_\_\_\_

**Date & Name of MD given previous work restriction:** \_\_\_\_\_

**Was your problem gradual?**  **yes**  **no**

**Was your pain problem caused by an accident?**  **yes**  **no**

**If yes, was the accident**  **Employment related**  
 **Auto Accident**  
 **Other**  **DATE OF ACCIDENT**  
 \_\_\_\_\_/\_\_\_\_/\_\_\_\_  
 month / day / year

**State accident occurred in:** \_\_\_\_\_

Describe your pain: \_\_\_\_\_

How frequently do you have pain? CONSTANT \_\_\_\_\_ COMES & GOES \_\_\_\_\_ OTHER \_\_\_\_\_

← PLEASE **CIRCLE** THE NUMBERS YOUR PAIN RATES ON A SCALE OF 1-10: →

**No Pain** **Worst Pain Imaginable**  
**0**    **1**    **2**    **3**            **4**    **5**    **6**    **7**            **8**    **9**    **10**  
           DISCOMFORTING                    DISTRESSING                    HORRIBLE                    EXCRUCIATING

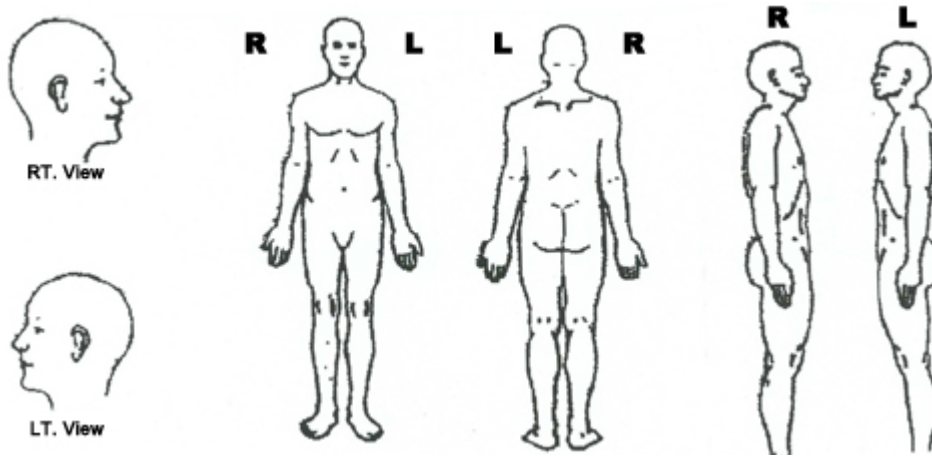
**CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE:**

- |   |   |                                    |
|---|---|------------------------------------|
| <input type="checkbox"/> NUMBNESS           | <input type="checkbox"/> DEPRESSION         | <input type="checkbox"/> STABBING  |
| <input type="checkbox"/> TINGLING           | <input type="checkbox"/> WEIGHT LOSS        | <input type="checkbox"/> SHOOTING  |
| <input type="checkbox"/> BURNING SENSATION  | <input type="checkbox"/> LOSS OF APPETITE   | <input type="checkbox"/> CRAMPING  |
| <input type="checkbox"/> INABILITY TO SLEEP | <input type="checkbox"/> MORE PAIN AT NIGHT | <input type="checkbox"/> HEADACHES |
|   |   | <input type="checkbox"/> THROBBING |

What **INCREASES** your pain?

- |  |   |                                |
|--|---|--------------------------------|
| <input type="checkbox"/> STANDING, WALKING | <input type="checkbox"/> BENDING (AT NECK/ WAIST) |                                |
| <input type="checkbox"/> DAMP WEATHER      | <input type="checkbox"/> FORWARD                  | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> DRIVING           | <input type="checkbox"/> BACKWARD                 |                                |

**PLEASE SHADE IN, ON THE DRAWING BELOW, THE AREAS WHERE YOU FEEL PAIN:**



**PREVIOUS TREATMENT:**

TREATMENT	YES	NO	HELPFUL	NOT
NERVE BLOCK/INJECTIONS				
SURGERY				
OCCUPATIONAL THERAPY				
PHYSICAL THERAPY				
TENS UNIT				
CHIROPRACTOR				
BIOFEEDBACK				
COUNSELING				
ACCUPUNCTURE				

<b>MEDICATIONS:</b>	<b>Prescribed By:</b>	<b>MEDICATIONS:</b>	<b>Prescribed by:</b>

Previous medication taken for pain not listed above? \_\_\_\_\_  
 Are you allergic to any medications? If yes, which ones? \_\_\_\_\_  
 \_\_\_\_\_

Circle any anticoagulants taken (Blood Thinners) Aspirin    Warfarin    Coumadin    Plavix    Lovenox

**SOCIAL HISTORY:**

	<b>YES</b>	<b>NO</b>
DRUG ABUSE HISTORY?		
ALCOHOL ABUSE HISTORY?		
DO YOU DRINK?		
DO YOU SMOKE?		
ARE YOU PREGNANT?		

**SURGICAL HISTORY:**

**DATE**


**REVIEW OF SYSTEMS:**

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
FEVER			ERECTILE DYSFUNCTION		
WEIGHT LOSS			BLADDER PROBLEMS		
WEIGHT GAIN			HEADACHES		
BLURRY VISION			BACK PAIN		
DOUBLE VISION			NECK PAIN		
VISION LOSS			MUSCLE PAIN		
SHORTNESS OF BREATH			RASHES		
SNORING			DEPRESSION		
WHEEZING			MENTAL PROBLEMS		
DIFFICULT SWALLOWING			LOSS OF BALANCE		
ABDOMINAL PAIN			MUSCLE WEAKNESS		
CONSTIPATION			NUMBNESS		
BLOODY STOOL			TINGLING		
HEART PROBLEMS			ALLERGIES		
BLEEDING DISORDER			DIABETES OR THYROID PROBLEMS		

**MEDICAL HISTORY:**

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
EASY BLEEDING			STROKE		
CANCER			SEIZURES		
HAS YOUR CANCER SPREAD?			TUBERCULOSIS		
DIABETES			ULCERS		
DO YOU TAKE INSULIN?			KIDNEY PROBLEMS		
HEART PROBLEMS			EMPHYSEMA		
HAVE YOU HAD A HEART ATTACK?			ASTHMA		
IRRREGULAR HEART BEAT			ARTHRITIS		
HEART FAILURE			HIV		
HIGH BLOOD PRESSUR					
HEPATITIS B or C			OTHER		