DATE OF VISIT ____________

INITIAL PATIENT VISIT - SPINE

PATIENT'S NAME ____________ DATE OF BIRTH ___/___/___ AGE ____ SEX: ☐ M ☐ F

Who referred you to us? ____________

Family Physician: ____________ Physician's Phone Number ____________

PLEASE STATE COMPLAINTS YOU WILL BE ASKING YOUR PHYSICIAN TO EVALUATE

____

____

ALLERGIES

Please identify what you are allergic to and what type of reaction you have:

☐ MEDICATIONS ____________ REACTION ____________

☐ FOODS ____________ REACTION ____________

☐ IODINE (topical) ____________ REACTION ____________

☐ IODINE (injectable) ____________ REACTION ____________

☐ LATEX ____________ REACTION ____________

☐ ADHESIVES ____________ REACTION ____________

☐ OTHER ____________ REACTION ____________

☐ NO KNOWN ALLERGIES

MEDICATIONS

I take the following medications:
(All prescriptions and over-the-counter, including aspirin and birth control pills):

____________ ____________

____________ ____________

____________ ____________

____________ ____________

HERBAL SUPPLEMENTS ____________

OPERATIONS, TREATMENTS, HOSPITALIZATIONS

I have had the following Operations, Treatments and/or Hospitalizations:

____________ DATE ____________

____________ DATE ____________

____________ DATE ____________

SOCIAL HISTORY

Do you smoke? (Complete if age 12 and greater)

☐ NO If you have quit smoking, when did you quit? (Month and year) ____________

☐ YES Number of packs per day ____________ Number of years smoking ____________

Do you use smokeless tobacco? (Complete if age 12 and greater)

☐ NO If you quit smokeless tobacco, when did you quit? ____________

☐ YES What do you use? ____________ Number of years using smokeless tobacco? ____________

PATIENT'S NAME ______________________

INITIAL PATIENT VISIT - SPINE

Do you drink alcoholic beverages? ☐ NO ☐ YES HOW OFTEN

☐ 1 DRINK PER MONTH ☐ 1-2 DRINKS PER WEEK ☐ 2-6 DRINKS PER WEEK ☐ 6 DRINKS OR MORE PER WEEK

Do you use recreational drugs? ☐ NO ☐ YES (Please list) ______________________

Osteoporosis Screening? (Complete if age 65 and greater)

- ☐ No falls, no injury?
- ☐ Fall in past year or fall with injury? How many? ______________________
- ☐ Screened for Osteoporosis (Bone Mineral Density Test, DEXA Scan)? When? ______________________

MEDICAL CONDITIONS Have you, or your family ever had any of the following problems?

	SELF	PARENTS	SIBLINGS
Glaucoma			
Heart Disease			
Heart Attack			
High Blood Pressure			
Lung Disease			
Emphysema			
Asthma			
Ulcer			
Colitis			
Difficulty in Urinating			
Kidney, Bladder, Prostate problems			
Arthritis			
Gout			
Osteoporosis			
Rheumatoid Arthritis			
Parkinson's Disease			
Seizures			
Diabetes			
Thyroid Disorder			
Bleeding Problems			
Sickle Cell Anemia			
Hepatitis			
HIV			
Cancer (note type)			
Sleep Apnea			

IS THIS A WORKMEN'S COMPENSATION INJURY? ☐ YES ☐ NO (If no, proceed to page)

If you answered yes, describe how the injury occurred ______________________

____

____

Date of injury ______________________

Last day of work ______________________

Previous workmen's compensation claims (Year of injury and surgery required)

____

Name of your attorney for making your file accessible:

____

PATIENT'S NAME ______________________

INITIAL PATIENT VISIT - SPINE

Associated symptoms (Check all that apply)

☐ PAIN ☐ TINGLING ☐ WEAKNESS IN MY: ☐ ARMS/HANDS ☐ LEGS/FEET

☐ OR OTHER ______________________

Timing of symptoms (Check all that apply) **Pain is increased:** ☐ SITTING ☐ STANDING ☐ WALKING

☐ LYING DOWN ☐ LEGS/FEET IN MY: ☐ NECK ☐ BACK ☐ ARM ☐ LEG ☐ OTHER

Rate your pain (On a scale of 0-10) 0 = No Pain 10 = Maximum Pain ________

Previous treatment for this injury (List medications, physical therapy, cortisone/epidural injections, chiropractic treatment, etc.) ______________________

What can't you do because of your pain? ______________________

____

Is surgery an option for you if your condition fails? ☐ YES ☐ NO

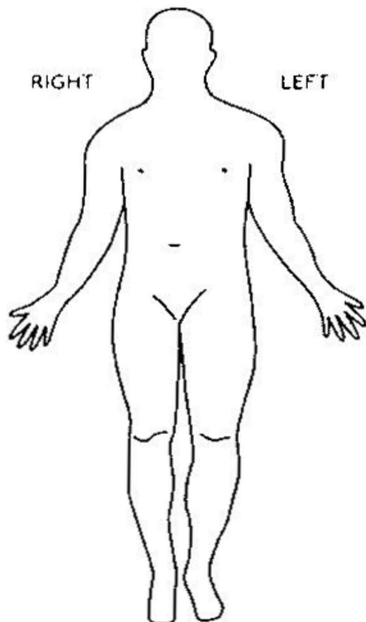
Not-operative treatment? ☐ YES ☐ NO

Do you use any of the following assistive devices? (Check all that apply)

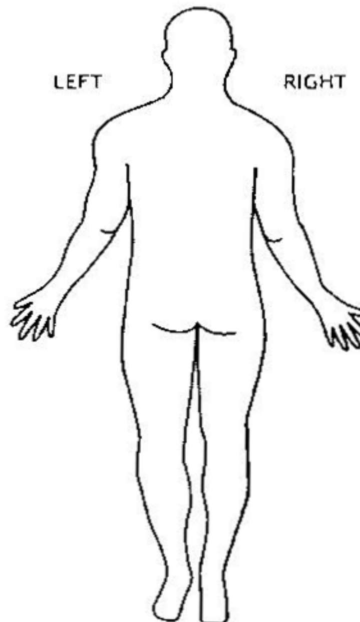
☐ GLASSES ☐ CONTACTS ☐ HEARING AIDES ☐ PROSTHETIC LIMBS ☐ CANE ☐ WALKER

PLEASE DRAW ON THE FIGURE BELOW WHERE YOUR PAIN IS, WHERE IT RADIATES, AND WHAT TYPE OF PAIN IT IS NUMBNESS ===== PINS & NEEDLES ++++++ BURNING XXXXX STABBING \\\\\

FRONT



BACK



THE ABOVE LISTED INFORMATION IS CORRECT TO THE BEST OF MY ABILITY:

PATIENT'S SIGNATURE ______________________ DATE ____________

PHYSICIAN CO-SIGNATURE ______________________ DATE ____________