**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_ Account #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age\_\_\_\_\_ Referring Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Med Mgr \_\_\_\_\_\_\_\_\_\_\_**

**Reason for Visit (CC) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Location of Worst Pain Neck Head Right Arm Left Arm**

 **Mid Back Abdomen (Belly) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Low Back Left Leg Right Leg**

**Cause of Pain: Work Injury Auto Accident Personal Injury Other\_\_\_\_\_\_\_\_\_\_\_\_**

**What treatments have you previously had for this pain?**

* **Over the Counter Medications**
* **Prescription Medications**
* **Heat/Ice**
* **DME (Braces or TENS Units)**
* **Physical Therapy/Chiropractic Therapy**
* **Injection Therapy (Epidurals, Facet Nerve Blocks/Ablations, Trigger Point Injections, SI Injections)**
* **Spinal Surgeries(date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please List All Current Medications:**

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency (How often)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

***\*Please Use back of Form to List Any Additional Medications\****

**Please List All Allergies you have:**

|  |  |
| --- | --- |
| **Medication** | **Reaction** |
|  |  |
|  |  |
|  |  |
|  |  |

***\*Please Use back of Form to List Any Additional Allergies\****

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please List All Surgeries You Have Had:**

|  |  |
| --- | --- |
| **Surgery** | **Date** |
|  |  |
|  |  |
|  |  |
|  |  |

**Do you have any type of metal in your body? : Yes No**

**Are you currently or have you ever been treated for any of the following?**

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | **Condition** |
|  |  | **Asthma** |
|  |  | **COPD** |
|  |  | **High Blood Pressure** |
|  |  | **Diabetes** |
|  |  | **GERD/Heart Burn** |
|  |  | **Irritable Bowel Syndrome** |
|  |  | **Heart Disease** |
|  |  | **Kidney Disease** |
|  |  | **Psychological/Psychiatric (Depression, Anxiety, Bipolar, Schizophrenia, ADD, OCD)** |
|  |  | **Seizures** |
|  |  | **Sleep Disorders/Sleep Apnea** |
|  |  | **Stroke** |
|  |  | **Thyroid Disease** |
|  |  | **Rheumatoid Conditions (RA, Fibromyalgia, PA, OA, Lupus, Etc.)** |
|  |  | **Other:** |

**Do any of the following conditions run in your family?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Yes** | **No** | **Condition** | **Yes** | **No** | **Condition** |
|  |  | **Bleeding Disorder** |  |  | **Heart Attacks** |
|  |  | **Diabetes** |  |  | **Hypertension (High Blood Pressure)** |
|  |  | **Migraines** |  |  | **Aneurysms** |
|  |  | **Stroke** |  |  | **Heart Disease** |
|  |  | **Seizures** |  |  | **High Cholesterol**  |
|  |  | **Drug Abuse** |  |  | **Alcohol Abuse** |

**Are you currently pregnant? Yes No Have you ever used Tobacco products? Yes No**

**Have you ever used any form of Alcohol? Yes No Have you ever used any type of illegal drug? Yes No**

**Have you ever been arrested? Yes No**

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Review Of Systems**

**Do you ever experience any of the following?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Yes** | **No** | **Symptom** | **Yes** | **No** | **Symptom** |
|  |  | **Fatigue** |  |  | **Rash** |
|  |  | **Change in Appetite**  |  |  | **Psoriasis** |
|  |  | **Sleeping Problems** |  |  | **Eczema** |
|  |  | **Double Vision** |  |  | **Loss of Balance** |
|  |  | **Impaired Vision** |  |  | **Seizures** |
|  |  | **Other Vision** |  |  | **Change in Alertness** |
|  |  | **Changes in Vision**  |  |  | **Joint Pain** |
|  |  | **Headaches** |  |  | **Hip Pain** |
|  |  | **Vertigo** |  |  | **Joint Swelling** |
|  |  | **Nasal Discharge** |  |  | **Limitation of Motion** |
|  |  | **Post Nasal Drip** |  |  | **Muscle Cramps** |
|  |  | **Dentures** |  |  | **Back Pain** |
|  |  | **Hearing Loss** |  |  | **Back Spasms** |
|  |  | **Chest Pain** |  |  | **Painful Joints** |
|  |  | **Irregular Heart Beat** |  |  | **Stiffness** |
|  |  | **Cardiac Murmur** |  |  | **Leg Cramps** |
|  |  | **Blacking out/Fainting** |  |  | **Head Pain** |
|  |  | **Shortness of Breath** |  |  | **Neck Pain** |
|  |  | **Wheezing** |  |  | **Shoulder Pain** |
|  |  | **Cough** |  |  | **Feet Cold All of The Time** |
|  |  | **Nausea** |  |  | **Feel Uncomfortably Hot** |
|  |  | **Vomiting** |  |  | **Anxiety** |
|  |  | **Diarrhea** |  |  | **Depression** |
|  |  | **Constipation** |  |  | **Hallucinations** |
|  |  | **Heart Burn** |  |  | **Easy Bleeding** |
|  |  | **Dysuria** |  |  | **Easy Bruising** |
|  |  | **Hematuria (blood in urine)** |  |  | **Food Allergies** |
|  |  | **Kidney Stones** |  |  | **Medication Allergies** |
|  |  | **Kidney Dialysis**  |  |  | **Severe Reaction to Insect Bites** |

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nurse/MA:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**