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MEDICAL FORM I

Patient's Name: _____ **Age:** _____ **Date:** _____
Primary Care Physician: _____ **Referring Physician:** _____ **Phone:** _____
Was this injury due to an auto accident? ☐YES ☐NO **Did this occur at Work?** ☐YES ☐NO **Date of Injury:** _____
Disability and Litigation: SSI/SSDI ☐YES ☐NO **Workers Comp?** ☐YES ☐NO
Have you retained a lawyer? ☐YES ☐NO **Is there a lawsuit Involved?** ☐YES ☐NO
Referred By: _____

PAST MEDICAL HISTORY

Chief complaint: _____
Duration: _____
Describe activities which aggravate or worsen your your symptoms/pain: _____
_____
_____
Describe activities which decrease your symptoms/pain:
_____
_____
Does the pain radiate? _____
If so, describe any numbness, tingling or muscle weakness?
_____
_____

	No	Yes	Please Specify
Anemia/Blood Disease	☐	☐	_____
Arthritis	☐	☐	_____
Back/Neck	☐	☐	_____
Cancer	☐	☐	_____
Depression	☐	☐	_____
Diabetes	☐	☐	_____
GI	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Osteoporosis	☐	☐	_____
Lung Disease	☐	☐	_____

Other (Please specify) _____

What treatments have you received?

☐ *NSAID's:* ☐ Naproxen ☐ Motrin ☐ Aspirin ☐ Celebrex ☐ Other: _____
☐ *Pain Medications:* ☐ Neurontin ☐ Lyrica ☐ Ultram ☐ Other: _____
☐ *Narcotics* ☐ Percocet ☐ Oxycontin ☐ Morphine ☐ Hydrocodone ☐ Other: _____
☐ Epidural Injection: Date: _____ ☐ Oral/Injected Steroids
☐ Acupuncture/Chiropractor ☐ Physical Therapy ☐ Brace ☐ TENS/Ultrasound

Do medication help? ☐ No ☐ Somewhat (1/3 better) ☐ Moderately (1/3 – 2/3 better) ☐ Greatly (>2/3 better)
When does pain occur: ☐ At rest ☐ With activity ☐ At night
Your Problem has: ☐ Improved ☐ Worsened

HAS ANYONE IN YOUR FAMILY EXCLUDING YOUR SPOUSE HAD ANY OF THESE PROBLEMS?

No details Known? ☐
AIDS/HIV? ☐
Alcohol abuse? ☐
Alzheimer's/Memory Loss? ☐
Anemia? ☐
Arthritis? ☐
Asthma? ☐
Colon cancer? ☐
Lung cancer? ☐
Breast cancer? ☐
Cervical cancer? ☐
Prostate cancer? ☐
Depression? ☐
Diabetes? ☐
Drug abuse? ☐
Gout? ☐
Heart Disease? ☐
Hypertension? ☐
Kidney disease? ☐
Liver disease? ☐
Muscle disease? ☐
Osteoporosis? ☐
Seizures? ☐
Stomach ulcers? ☐
Stroke? ☐
Other problems? ☐

TEST TAKEN FOR YOUR CURRENT PROBLEM?

X-ray? ☐ _____
MRI? ☐ _____
CT scan? ☐ _____
Bone scan? ☐ _____
EMG/NCS? ☐ _____
Bone density test? ☐ _____
Ultrasound or Doppler? ☐ _____
Blood or other lab test? ☐ _____
Other: _____

FEMALE'S ONLY

	NO	YES
Are your menstrual cycles regular?	☐	☐
Menopause?	☐	☐
Currently Pregnant?	☐	☐

Previous Pregnancies: _____

SURGERIES

	NO	YES	DATE	DESCRIBE
Heart	☐	☐	_____	_____
Lung	☐	☐	_____	_____
Abdominal	☐	☐	_____	_____
Neck	☐	☐	_____	_____
Back	☐	☐	_____	_____
Orthopaedic	☐	☐	_____	_____
Other	☐	☐	_____	_____

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MEDICAL FORM II

Patient's Name: _____ Age: _____ Date: _____

SOCIAL HISTORY

Occupation: _____

Hours/week: ☐ More than 40 ☐ 20-40 ☐ Less than 20 ☐ None

Type of work: ☐ Heavy Labor ☐ Labor with restrictions ☐ Mostly sitting ☐ Sedentary

Have you changed your job or activity level because of your spine problem? ☐ Yes ☐ No

Currently how often do you exercise? ☐ Everyday ☐ Every few days ☐ Less than once/week

Education: ☐ High school ☐ College ☐ Graduate school

Smoking: ☐ Never smoked ☐ Quit more than six months ago Quantify: _____

Alcohol: ☐ None ☐ Less than 10 per week ☐ More than 10 per week

Married: ☐ Yes ☐ Single ☐ Divorced ☐ Widow/Widower

Children: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than 5

REVIEW OF SYSTEMS

GENERAL	NO	YES	DETAILS
Fever	☐	☐	_____
Chills	☐	☐	_____
Night sweats	☐	☐	_____
Weight loss	☐	☐	_____

GI	NO	YES	DETAILS
Abdominal Pain	☐	☐	_____
Ulcer	☐	☐	_____
Bleeding	☐	☐	_____
Indigestion	☐	☐	_____
Constipation	☐	☐	_____

NEUROLOGY	NO	YES	DETAILS
Headache	☐	☐	_____
Black Outs	☐	☐	_____
Balance Difficulties	☐	☐	_____
Seizure	☐	☐	_____

URINARY	NO	YES	DETAILS
Stones	☐	☐	_____
Infection	☐	☐	_____
Frequent Urination	☐	☐	_____
Indigestion	☐	☐	_____

REPRODUCTIVE	NO	YES	DETAILS
Discharge	☐	☐	_____
Infection	☐	☐	_____
Sores	☐	☐	_____
Sexual Problems	☐	☐	_____

EYES/EARS	NO	YES	DETAILS
Visual Problems	☐	☐	_____
Double Vision	☐	☐	_____
Hearing Difficulty	☐	☐	_____

NOSE/THROAT	NO	YES	DETAILS
Discharge	☐	☐	_____
Pain	☐	☐	_____
Soreness	☐	☐	_____
Swelling	☐	☐	_____
Sinusitis	☐	☐	_____

MUSKULOSKELOTAL	NO	YES	DETAILS
Arthritis	☐	☐	_____
Swelling	☐	☐	_____
Pain	☐	☐	_____
Fracture	☐	☐	_____
Weakness	☐	☐	_____

CARDIAC	NO	YES	DETAILS
Chest Pain	☐	☐	_____
Shortness of Breath	☐	☐	_____
Difficulty Breathing	☐	☐	_____

HEMATOLOGIC	NO	YES	DETAILS
Anemia	☐	☐	_____
Bleeding Disorders	☐	☐	_____
Clots	☐	☐	_____

CHEST	NO	YES	DETAILS
Cough	☐	☐	_____
Asthma	☐	☐	_____
Bronchitis	☐	☐	_____

PSYCHIATRIC	NO	YES	DETAILS
Depression	☐	☐	_____
Bipolar	☐	☐	_____
Mood Swings	☐	☐	_____

SKIN	NO	YES	DETAILS
Rash	☐	☐	_____
Sores	☐	☐	_____

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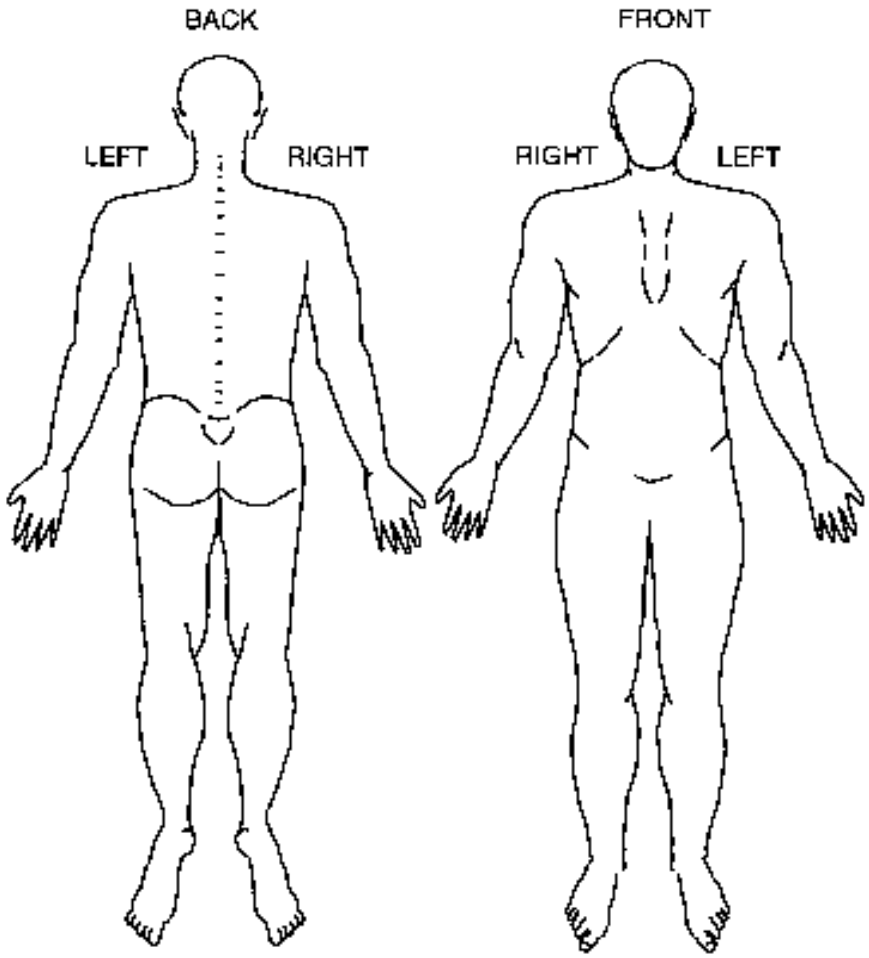
PAIN DIAGRAM

Patient's Name: _____ Age: _____ Date: _____

PAIN DIAGRAM

Mark the areas on your body where you feel the described sensation.
Use the appropriate symbol. Mark areas of radiation. Include all affected areas.
Tingling 0000
Pain XXXX
Numbness IIII



Put a mark through the line below to rate your pain intensity on average:
No pain----------worst possible pain
"0" "10"

Put a mark through the line below to rate your pain intensity at its worst:
No pain----------worst possible pain
"0" "10"

Please circle the appropriate words that best describe your pain:

ACHING	DULL	SHOOTING	CONSTANT	CRAMPING	BRIEF
BURNING	TIGHT	SORENESS	STABBING	TINGLING	SHARP
RADIATING	COLDNESS	NUMBNESS			