

Patient Form

Name: _____ Date: _____

Did a physician refer you to us today? Physician: Dr. _____ at _____

How did you hear about us? Magazine/Newspaper Website Yellow Pages Family/Friend

Explain your symptoms in detail for seeing the doctor today: *(i.e. lower back pain, headaches, etc.)*

When did this symptom first begin? Very first time: _____ Last time: _____

What event caused your symptoms? *(if known)*

Other Symptoms:

	YES	NO
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems (besides eyeglasses)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Urination difficulties:		
– Starting urine	<input type="checkbox"/>	<input type="checkbox"/>
– Losing urine	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems (clotting)	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Balance problems	<input type="checkbox"/>	<input type="checkbox"/>
Weakness in extremities: R L	<input type="checkbox"/>	<input type="checkbox"/>
Others (List)		

Allergies: list all drug allergies (also note if allergic to shrimp or IVP dye)

No known allergies *(please check box)*

Please answer all questions completely. Do not leave anything blank.

Are you presently taking any blood-thinning medications (i.e. Coumadin, Plavix, aspirin, or aspirin products)?

Yes – If yes, please list below No

Have you been diagnosed with any autoimmune diseases? (i.e. Lupus, rheumatoid arthritis, etc.)

Yes – If yes, please list below No

Are you currently taking any immune suppressant drugs?

Yes – If yes, please list below No

List all medications you are currently taking:

Drug	Strength	Times a day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List All Surgeries	Year
_____	_____
_____	_____
_____	_____
_____	_____

Illness:	YES	NO
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

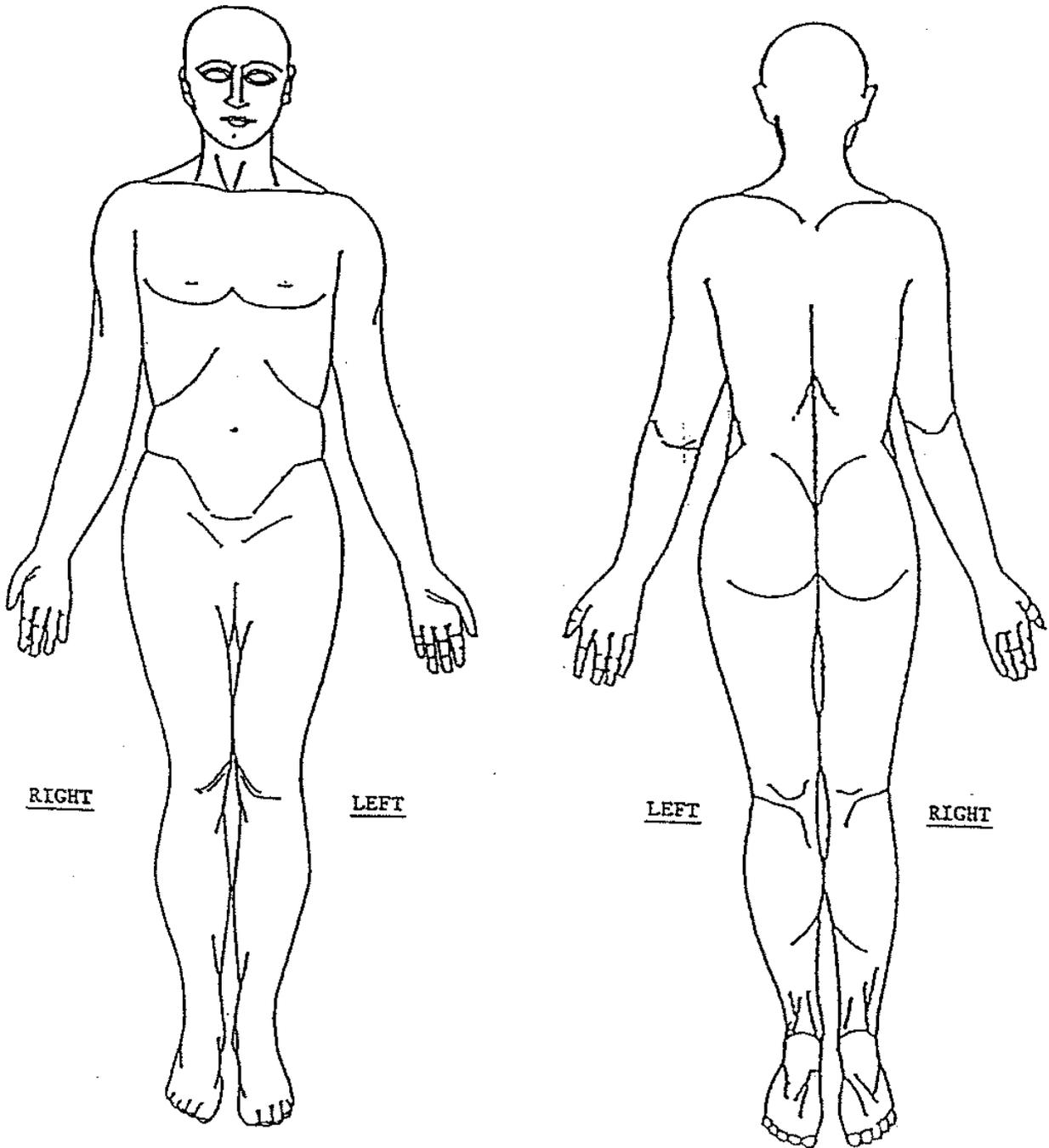
Please list all other past/present medical conditions:

Name: _____

On the scale below, circle your pain level, with "0" being no pain at all and "10" being the worst pain imaginable.

0 1 2 3 4 5 6 7 8 9 10

Please shade in area(s) of pain



Name: _____ Date: _____

Please assist us with specifics:

Have you been treated for this condition by another physician? Yes No

If so, which physician(s), and list ALL types of treatments, including DATES:

Have you been on anti-inflammatory medications within the past 3 months? Yes No

If so, how long? _____ and name of medication _____

Have you had physical therapy for this condition within the past 3 months? Yes No

Have you had epidural blocks for this condition? Yes No

If so, how many? _____ Date of last block _____

Who did the blocks? _____

Where were the blocks done? _____

Family History: Please indicate maternal/parental grandparents, mom, dad, aunts, uncles, etc.

Spinal problems Yes No If yes, describe: _____

Bleeding disorders Yes No If yes, describe: _____

Heart disease Yes No If yes, describe: _____

Cancer (type) Yes No If yes, describe: _____

Diabetes Yes No If yes, describe: _____

Kidney disease Yes No If yes, describe: _____

Lung disease Yes No If yes, describe: _____

Social History:

Marital status: Single Married Divorced Remarried Widowed Separated

Work status: Working Not Working Student Retired

Disabled (reason): _____

Primary occupation: _____ Employer: _____

If not working, last date worked: _____

Do you smoke/dip/chew tobacco products? Yes No Amount/day: _____ # Years: _____

If quit, when? _____

Alcohol use: Yes No # beers/drinks per day: _____ # beers/drinks per week: _____

Have you used: Marijuana: Yes No Cocaine: Yes No Heroin: Yes No

Other: _____

Last time you used: _____ Any addiction problems: Yes No