

What relieves your pain? Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Spinal injections |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Epidural <input type="checkbox"/> Facet Injections <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Active exercise | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> TENS unit | <input type="checkbox"/> Pain psychology |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Holistic or alternative treatments |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Manipulation | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Other – Specify: | |

Do you have any problems with bowel, bladder, or sexual functions?

- None
- No problems except for occasional constipation
- Difficulty controlling bladder functions
- History of urinary tract infections
- Sexual problems secondary to pain
- Physical problems with sexual function other than pain
- Other - Specify

Do you have any difficulty walking?

- No
- Yes, can walk less than a mile
- Yes, can walk only 1-2 blocks
- Yes, can walk unlimited distance
- Yes, non-ambulatory

Are you right or left handed?

- Right handed
- Left handed
- Ambidextrous

Current Medications–

What medications are you currently taking, and for what medical problem? Attach list or use back if necessary

<i>Name:</i>	<i>Dosage:</i>	<i>Frequency:</i>	<i>Notes:</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies:

Medication	Reaction	Medication	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please provide name and address of your current Pharmacy: (You must complete this question)

Medical History: (please check any/ all of the following that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke/CVA |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Murmur | <input type="checkbox"/> Swelling in Legs/Feet |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Hepatitis A/B/or C | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Malaria | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Diabetes (Type 1 or 2) | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Musculoskeletal Disorder | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Non-Healing Wounds | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoarthritis | |
| | <input type="checkbox"/> Osteoporosis | |

SURGICAL HISTORY

What surgery have you had (**including spine or back surgery**)? Attach list or use back if necessary

Date:	Place:	Surgeon:	Procedure:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any of the following complications of surgery?

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Poor Wound Healing | <input type="checkbox"/> Blood clot in legs |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Nonunion of fusion/ fracture | <input type="checkbox"/> Other – Specify |



WORK HISTORY

Is your injury job related?

Yes No

If Yes: Date of Injury _____

Have you ever filed a prior work comp injury?

Yes No

If Yes, Date: _____

Are you currently receiving or seeking disability for this condition? Yes No

What is your current work status?

Regular Employment - No Restrictions

Full-Time with Restrictions

Homemaker

Part-Time by Choice

Part-Time for Medical Reasons

Retired by Choice

Retired by Medical Reasons

Unemployed - Looking for work without restrictions

Unemployed - Looking for light duty

Unemployed

Student

Other – Specify

Who is the primary treating physician for your work comp injury?

Have you returned to work?

Yes No If Yes, _____

Do you have an attorney?

Yes No If Yes, _____

What is your occupation?

Who is your current employer:

Have you attempted to return to work since the onset of your pain?

Yes – When did you attempt this return?

No

This does not apply to me.

When did you last work? _____

Physical activities at work (check all that apply)

Sitting Standing Repetitive lifting Heavy lifting Phone use

Computer use Heavy equipment operation Driving



Please use this space to explain any detail that the doctor needs to know:

SOCIAL HISTORY

Are you:

- married
- partner
- single
- divorced
- widow/widower
- separated

With whom do you live?

- living with spouse
- living alone
- living with children
- living with parents
- living in an assisted living community
- other

Do you have children?

Yes No Yes: _____

Do you smoke cigarettes?

- No - I have never smoked
- No - I quit _____ months / years ago
- Yes _____ packs per day
- Currently chew tobacco / snuff.

Do you drink alcoholic beverages?

Yes No
Amount: _____

Do you use illicit drugs (Marijuana, Cocaine, etc...)?

Yes Howlong?: _____
 No

What is the highest grade you completed or degree you received? _____



FAMILY HISTORY

Do any of your blood relatives have any of these diseases?

- None
- Back or Neck Problems
- Rheumatoid Arthritis
- Cancer
- Coronary Artery Disease
- high blood pressure
- lung problems
- diabetes
- kidney problems
- ulcers
- heart problems
- gout
- epilepsy (seizures)
- stroke
- thyroid (too little)
- thyroid (too much)
- anemia
- Other – Specify



Please Do Not Write in the "Notes" section

NOTES: _____



REVIEW OF SYSTEMS

Please mark all of the following that apply to you.

Constitutional

- Low fever
- High fever
- Chills
- Loss of appetite
- Unexplained weight loss
- Unusual tiredness
- Insomnia
- Sedation

Eyes

- blurred vision
- double vision
- abnormal vision
- glasses
- contact lenses

Ears, Nose, Mouth, Throat

- ringing in ears
- room spinning
- dizziness
- sinus pain
- sinus drainage
- mouth sores
- sore throat

Cardiovascular

- high blood pressure
- angina (chest pain)
- trouble breathing
- trouble breathing when flat
- ankle swelling
- heart attack
- congestive heart failure
- mitral valve prolapse
- abnormal heart rhythm
- heart murmur / arrhythmia

Respiratory

- heavy cough
- cough up sputum
- cough up blood
- pneumonia
- asthma

Gastrointestinal

- nausea
- stomach pain
- vomiting
- vomiting blood
- vomiting "coffee grounds"
- ulcers
- hiatal hernia
- constipation / diarrhea
- change in bowel habits
- blood in stool
- black, tarry stools

Genitourinary

- painful urination
- blood in urine
- vaginal /penile discharge
- impotence
- loss of sexual desire
- painful sex
- kidney problems
- one kidney
- kidney failure
- dialysis
- kidney transplant
- venereal disease
- change in bladder habits
- urgency / hesitancy

Date of last menstrual period:

Musculoskeletal

- painful joints
- swollen joints
- redness of joints
- joint infection
- bone infection
- gout
- osteoarthritis
- rheumatoid arthritis
- ankylosing spondylitis
- osteoporosis
- osteomalacia
- sore muscles
- muscle spasms

Psychiatric

- depression
- want to die
- anxiety

Endocrine

- diabetes
- thyroid (too little)
- thyroid (too much)

Hematologic/Lymphatic

- unusual sweating
- unusual bleeding
- easy bruising
- mass (lumps or bumps)
- breast lump
- swollen glands
- anemia
- infection
- HIV
- AIDS
- hepatitis
- cancer: what type?

Integumentary (Skin)

- Skin Sores
- Skin Rash
- Itching
- Skin Cancer

Neurological

- fainting
- epilepsy (seizures)
- stroke
- memory problems



Please Do Not Write in the "Notes" section

NOTES: _____