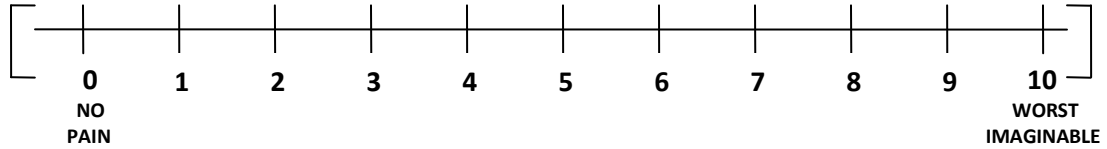




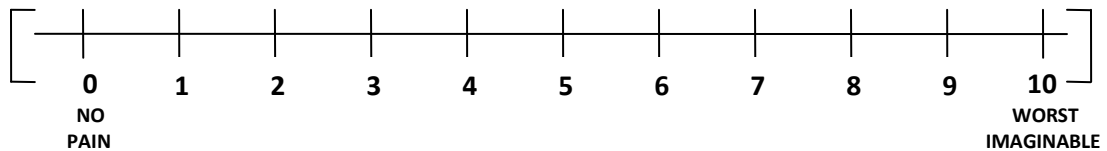
Pat. Name: \_\_\_\_\_

**SEVERITY OF PAIN:**

Please identify how much pain you experience while resting:



Please identify how much pain you experience during activity:



**TREATMENTS RECEIVED TO DATE:** (CHECK ALL THAT APPLY):

MEDICATIONS FOR THIS PROBLEM:      CURRENT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PREVIOUSLY MEDS TRIALED: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_ INJECTIONS: TYPE? \_\_\_\_\_ PHYSICAL THERAPY: WHERE? \_\_\_\_\_

\_\_\_ HOME EXERCISE      \_\_\_ MASSAGE      \_\_\_ CHIROPRACTIC

\_\_\_ OTHER \_\_\_\_\_

**TESTS OBTAINED TO DATE:**

\_\_\_ XRAYs \_\_\_\_\_ MRI \_\_\_\_\_

\_\_\_ MYELOGRAM \_\_\_\_\_ CT SCAN \_\_\_\_\_

\_\_\_ BONE SCAN \_\_\_\_\_ PET SCAN \_\_\_\_\_

\_\_\_ OTHER \_\_\_\_\_



Pat. Name: \_\_\_\_\_

**FAMILY AND SOCIAL HISTORY:**

DO YOU SMOKE/USE TOBACCO? \_\_\_\_\_ NEVER \_\_\_\_\_ #PACKS/DAY \_\_\_\_\_ # YEARS \_\_\_\_\_ QUIT WHEN: \_\_\_/\_\_\_/\_\_\_

DO YOU DRINK ALCOHOL? \_\_\_\_\_ NEVER \_\_\_\_\_ OCCASIONALLY \_\_\_\_\_ DAILY

DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE? \_\_\_\_\_ TYPE: \_\_\_\_\_

FAMILY HISTORY OF DISEASE (MARK ALL THAT APPLY) \_\_\_\_\_ HIGH BLOOD PRESSURE \_\_\_\_\_ HEART DIS.

\_\_\_\_\_ STROKE/TIA \_\_\_\_\_ DIABETES \_\_\_\_\_ ASTHMA \_\_\_\_\_ TUBERCULOSIS \_\_\_\_\_ THYROID DIS.

\_\_\_\_\_ OTHER: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (CIRCLE TYPE)

\_\_\_\_\_ ALLERGIES TO ANY METAL \_\_\_\_\_ RECENT FEVERS/CHILLS \_\_\_\_\_ ANY UNEXPECTED WEIGHT LOSS

\_\_\_\_\_ NIGHT SWEATS \_\_\_\_\_ BOWEL/BLADDER PROBLEMS \_\_\_\_\_ PROGRESSIVE NUMBNESS/WEAKNESS

\_\_\_\_\_ LUNG DIS: ASTHMA COPD EMPHYSEMA SHORTNESS OF BREATH WITH EXERCISE

\_\_\_\_\_ HEART DIS: CHEST PAIN MI HEART FAILURE VALVE DIS FIBRILLATION PALPITATIONS

IRREGULAR HEART BEAT SLOW/FAST HEART BEAT PACEMAKER:TYPE \_\_\_\_\_

\_\_\_\_\_ HIGH BLOOD PRESSURE \_\_\_\_\_ LIVER PROBLEMS: HEPATITIS:TYPE \_\_\_\_\_ JAUNDICE

\_\_\_\_\_ DIABETES \_\_\_\_\_ THYROID DIS. \_\_\_\_\_ ANEMIA \_\_\_\_\_ BLEEDING FROM NOSE/GUMS \_\_\_\_\_ EASY BRUISING

\_\_\_\_\_ STROKE/TIA \_\_\_\_\_ SEIZURES \_\_\_\_\_ TREMORS/PARKINSON'S \_\_\_\_\_ PARALYSIS \_\_\_\_\_ DOUBLE VISION

\_\_\_\_\_ ACID INDIGESTION \_\_\_\_\_ HIATAL HERNIA \_\_\_\_\_ ULCERS \_\_\_\_\_ COLITIS \_\_\_\_\_ CROHN'S DISEASE

\_\_\_\_\_ TB \_\_\_\_\_ HEPATITIS \_\_\_\_\_ HIV/AIDS \_\_\_\_\_ POLIO \_\_\_\_\_ MRSA STAPH INFECTION

\_\_\_\_\_ RECENT TRAVEL OUTSIDE OF USA -WHERE: \_\_\_\_\_

\_\_\_\_\_ DO YOU USE RECREATIONAL DRUGS OR DIET PILLS? TYPE: \_\_\_\_\_

\_\_\_\_\_ CANCER TYPE: \_\_\_\_\_

\_\_\_\_\_ DEPRESSION \_\_\_\_\_ BIPOLAR DIS. \_\_\_\_\_ SCHIZOPHRENIA \_\_\_\_\_ OTHER: \_\_\_\_\_

\_\_\_\_\_ SKIN RASH \_\_\_\_\_ PSORIASIS \_\_\_\_\_ ECZEMA \_\_\_\_\_ UNUSUAL SKIN LESION OR BIRTHMARK

THE INFORMATION THAT I HAVE PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient's Signature & Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Physician's Signature & Date