Todays Date:_____ **Confidential Patient Information**

Please read these questions LINE by LINE and carefully answer them to the best of your ability.
*Thank you for taking the time to **Fill Everything Out** .... This form will help Your Doctor - Help YOU !*

Name:_____ Age _____ Height _____ Weight _____ Sex: M / F

Date of Birth _____ SSN: _____-_____- _____

Address (street):_____ **City:**_____ **State:**_____

Zipcode:_____ **Phone Number: (**_____**)**_____**-**_____
Email:_____

Insurance: PPO / Medicare / HMO / Self Pay / Accident / Workers Compensation

Insurance Co:_____ ___ Claim #: _____

Employer: _____ Job Title_____ Duties _____ Working ? _____
Do you have pain as a result of (work/auto) injury? Y / N Date of Accident - Injury(s): _____

Referring Doctor(s) Tel#: _____ MD or Chiropractor _____
Pharmacy Name and Tel #: _____
Current Health Concerns: ***Why have you come to see the Doctor:***
1. _____
2. _____ 3. _____ 4. _____

Pain Scale*:** ***Please Circle #: *Please rate your.* ***0*** *= no pain, to* ***10****=worst pain imaginable*
0 1 2 3 4 5 6 7 8 9 10

Details of Injury: *How did you get hurt? When ?*
_____
_____
_____

***Car Accidents**: Circle as applies. Who was at fault?*

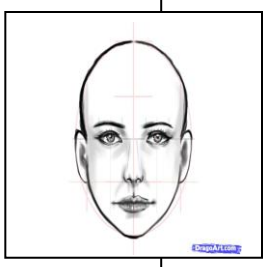
Impact: Rear –Side - Corner	Airbags Deployed	Police	Medical Evaluation	X-Rays	Past Accidents
Driver	Secondary Impact	Paramedics.	Chiropractic	MRI	Working
Passenger	Head Impact	Emergency Room	Physical Therapy	Nerve Testing	Disabled
Seat Belted	Contusions Lacerations	Hospital	Injections	Ultrasound Testing	

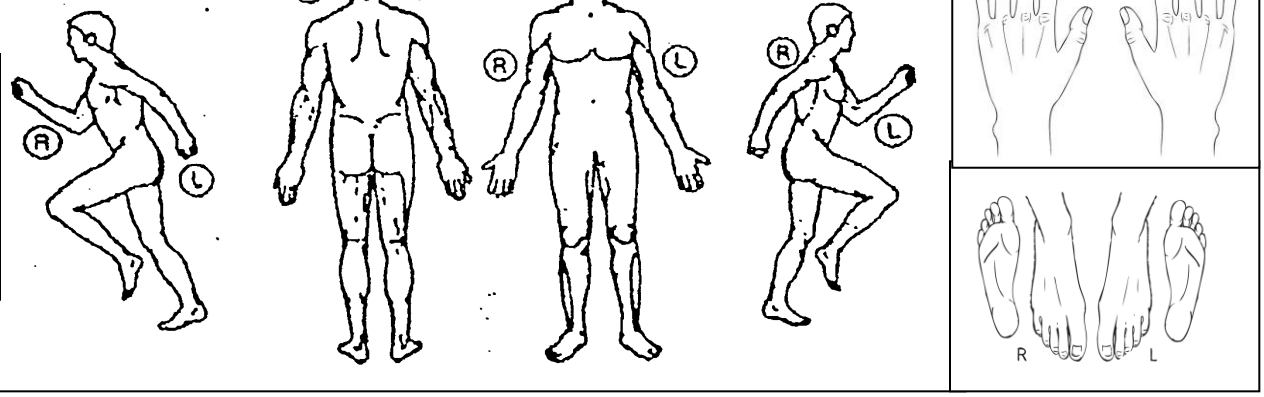
***Work Accident - Injury*: Date of Injury: ____ Accepted by Insurance? ____ Disability Payments ?**
Pain Description: ***Please Circle any positive*** *words which best describe your pain?*

Aching	Heavy	Cramping	Stinging	Numbing	Annoying
Dull	Brief	Stabbing	Tingling	Hotness	Intense
Soreness	Constant	Burning	Shooting	Coldness	Excruciating
Tight	Severe	Sharp	Radiating	Transient	Unbearable

Drawing: *This is very important !* Is there any numbness / tingling / weakness / swelling? Where?

Draw Shade where you hurt:





What makes the pain **Worse**? (Circle appropriate activity)? Describe activities which aggravate your pain:

Sitting	Bending	Turning	Driving	Reaching	Intimate Relations
Standing	Carrying	Twisting	Running	Other	Rising from a chair
Walking	Lifting	Extending	Stress	Lying Down	Repetitive Activity

What makes your pain **Better**?

Rest	*Bending*	*Stretching*	*Walking*	*Exercise*	*Activity*
Ice	*Heat*	*Massage*	*Physical Therapy*	*Medication*	*Injections*
Lying down	*Sleep*	*Sitting*	*Chiropractic*		*Other*

Special Studies:	**Year**	**By Who**		Diagnostic Injections
X-Ray	CT Scan	Discogram	Ultrasound Testing	Nerve Testing
MRI	Bone Scan	Arthrogram	Myelogram	

Treatments you have had: Circle any positives. Received When? _____ Helping? _____ By who? _____

Chiropractic	TENS	Medication	**Injections**: Blocks	Facet Joint injections
Physical Therapy	Traction	Biofeedback/Hypnosis	Nerve Block / Pain	Joint Inj: Hip Knee Shoulder
Acupuncture	Massage	Psychiatrist	Epidural	Trigger Point
Acupressure	Exercise	Psychologist	Spinal blocks	**Surgery**: *What kind…*
Yoga Stretching	Heat Ice	Pain Clinic	Disc Injections	

_____

Are you: ( ) Improved ( ) Worsened ( ) Same - why? _____

Medical History: Circle any positives: HEALTHY ?? Chronic Pain Opioid Dependence

Anemia	Acid Reflux Gastritis	Drug Abuse Alcohol Abuse	Diabetes I - II	Hyper- Thyroid Hypo - Thyroid	Falling Giving way of Limb / joints
Arthritis Rheumatoid Dz	GI Disorder Ulcers	Tylenol overuse Ibuprofen Abuse	Parkinson's Tremors	Infections Abscess	Hernia Colitis
Angina Heart Attack	Cholelithiasis Gallbladder	COPD Asthma	Rheumatic Fever	Obesity Gastric Bypass	Gaining Weight? How many pounds
AIDS-HIV SexTransmitted	Bowel Incontinence	Cholesterol Lipids	Heart Failure myopathy	Osteoporosis Fracture	Chronic Fatigue Syndrome Gout
Blindness Glaucoma	Bladder Infections	Hypertension Hypotension	Hepatitis/ Jaundice	Spinal Injury Spine Surgery	Fibromyalgia Muscle Aches
Birth Defect Genetic Illness	Bladder Incontinence	Arrhythmia Irregular Heart	Liver Damage Liver Failure	Stroke /Paralysis TIA	Anxiety Stress? Phobias Panic Attacks
Bleeding Hemophilia	Kidney Failure Infections	Atrial Fib	Mental Disorder Dementia	Scoliosis Spondylolisthesis	Sleep Apnea Snoring CPAP
Blood Clots DVT	Lung Pneumonia	Epilepsy Seizures	Shingles Herpes	Sexually Transmitted Dz	Hours of sleep per night:
Blood Thinners	Tuberculosis	Smokers Cough	Migraines	Vascular Dz	Depression *Suicidal Thoughts*?
Cancer of	Pancreatitis	Lymphoma Leukemia	Skin Disease Rash	Aortic Aneurism Brain Carotid Dz	Other

Surgical History: Type and year: _____

Medications: Please list all medications and supplements: *What Opioid medications do you take?*

Name	*Dose*	*How Often?*	X	***Name***	*Dose*	*How Often?*
			X			
			X			
			X			
			X			

Taking... *Circle…*
Blood Thinners ? Aspirin, **Coumadin**,Warfarin, **Plavix**,Clopidogrel **Pradaxa** (Dabigatran) **Xarelto** (Rivaroxaban); **Eliquis** (Apixaban)
Opioids ?: Have you ever taken: Morphine, Oxycodone, OxyContin, Methadone, Dilaudid, Nucynta, Fentanyl (Duragesic),Tramadol,

ALLERGIES ? _____ **Sensitive** *to medications* **?** _____

Females: *Do think you may be* ***Pregnant****? Y / N please notify staff !*

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Systems Review: *Circle if you have problems with any of the following areas at this time*. **Head:** Headaches Seizures
Eyes: Redness Blurry Vision Double vision Eye Pain **/ Ears:** Ringing/Buzzing, Loss of Hearing, Pain **Throat:** Hoarseness, Drainage **Nose:** Bleeding Drainage Allergies
Abdomen: Cramping Pain Ulcer Nausea **Kidney/ Bladder/ Genitalia:** Incontinence, Frequency/Urgency, Blood in urine**. Heart/Circulation:** Murmur Chest Pain Heart failure
Lungs / Breathing: Pain with deep breath Persistent Cough Blood Wheezing / Shortness of Breath Infections
Bones/Joints: Muscle Weakness Joint Stiffness Pain Swelling Grinding/ Popping Leg Swelling
Emotional/ Psychological: Depression Anxiety Stress at Work Thoughts of Suicide Thoughts/Acts of Violence Loss of Appetite
Current **Infection** of any kind? (Y) (N) *Please notify staff !* Where?_____

Do you have an Advance Medical Directive / Will ? Please provide a copy. Comments:

_____

_____

Patient Declaration: *The information given in this history questionnaire was provided by myself with or without an interpreter and is true. I understand and authorize the release of my medical records to my insurer, employer, workers compensation carrier and any other party involved, as is necessary to process this claim.*

Signature of Patient _____ Date _____

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