NAME: ______________________________ DATE: ______________

BIRTHDATE: ____/____/____ HEIGHT: ____FT. ____IN. WEIGHT: ________ LBS

A. 1. Referring doctor name and full address: ______________________________

____

If not referred, how did you choose this office? ______________________________

2. Internist or family doctor name and address: ______________________________

____

3. Chief complaint (Check all that apply):
   - □ Neck Pain
   - □ Back Pain
   - Arm: □ Pain □ Numbness □ Weakness
   - Leg: □ Pain □ Numbness □ Weakness
   - □ Other ______________________________

4. Your Age: ______ Years ______ Months

5. Your Gender: □ Male □ Female

6. How long has the pain (or your problem) been present? ______________________________

7. Has your problem worsened recently? □ No □ Yes – How recently? ______________________________

____

8. What started the pain (or problem)? ______________________________

____

B. PATIENT MEDICAL HISTORY: Check all that apply: □ None apply

□ Heart Attack
□ Heart failure
□ High blood pressure
□ Osteoarthritis
□ Rheumatoid arthritis
□ Ankylosing spondylitis
□ Gout
□ Osteoporosis
□ Diabetes
□ Stroke
□ Seizure
□ Mental Illness
□ Kidney stones
□ Kidney failure
□ Cancer
□ Alcoholism
□ Lung disease
□ HIV
□ AIDS
□ Tuberculosis
□ Asthma
□ Blood clot in leg
□ Blood clot in lung
□ Stomach ulcers
□ Liver trouble
□ Hepatitis
□ Thyroid trouble
□ Bleeding disorders
□ Anemia
□ Serious injuries (explain) ______________
□ Other: ______________

C. SURGICAL HISTORY: Previous surgeries – List procedures, surgeon, and date. □ No Previous Surgeries

OPERATION	SURGEON	DATE

D. FAMILY MEDICAL HISTORY: Check all that apply: □ None apply

□ Stroke
□ Heart trouble
□ High blood pressure
□ Diabetes
□ Arthritis
□ Gout
□ Seizures
□ Spine problems
□ Mental Illness
□ Kidney trouble or stones
□ Cancer
□ Bleeding disorders
□ Alcoholism
□ Other: ______________

____

____

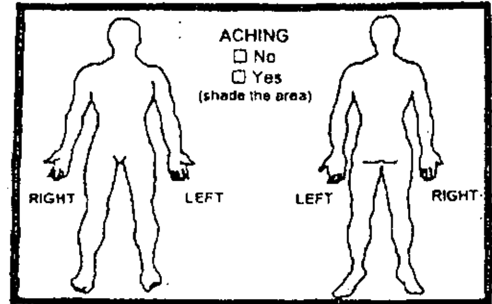
E. MEDICATIONS YOU TAKE: □ None

____

____

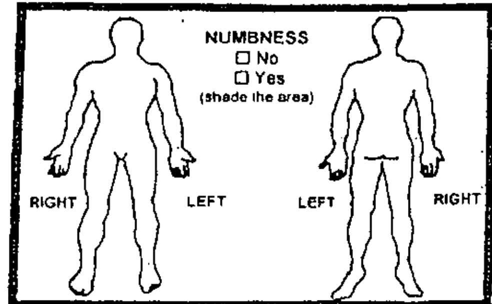
F. ALLERGIES TO MEDICATIONS: ☐ No known drug allergies

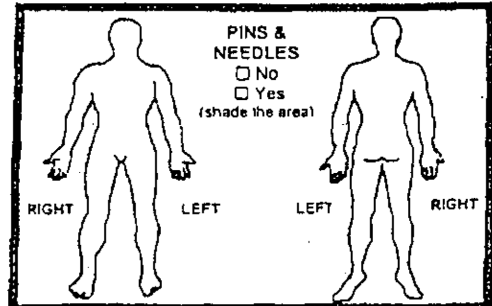
MEDICATION	Rash	Swelling Wheezing or Shock	Upset Stomach	Unknown Reaction	Other
________	☐	☐	☐	☐	________
________	☐	☐	☐	☐	________
________	☐	☐	☐	☐	________
________	☐	☐	☐	☐	________
________	☐	☐	☐	☐	________

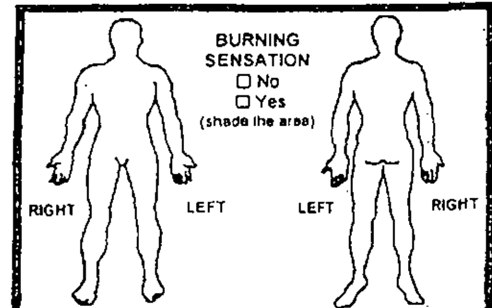


G. SOCIAL HISTORY:

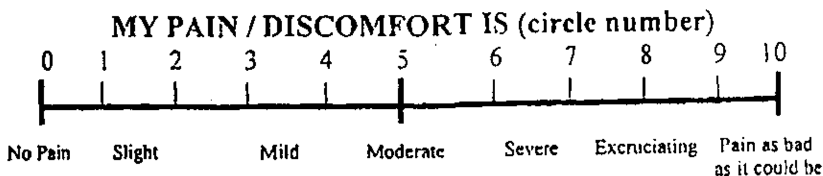
1. Work status: ☐ Homemaker ☐ Retired ☐ Disabled ☐ On leave ☐ Unemployed ☐ Working: __Full time __ Part time
   Occupation:____________________
2. Marital status: ☐ Married ☐ Single ☐ Co-habitating ☐ Widowed ☐ Divorced
3. Number of living children: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
4. I live: ☐ Alone ☐ With:____________________
5. Tobacco use: ☐ Never (skip to #6)
   ☐ Cigar ☐ Chew ☐ Pipe ☐ Cigarettes
   ________ packs per day for ________ years.
   ☐ Quit – When?____________________ after smoking
   ________ packs per day for ________ years (total)
6. Alcohol: ☐ Never or rare
   ☐ Social ☐ Frequently drunk (more than twice a week)
   ☐ Alcoholic ☐ Recovering alcoholic
7. Drug overuse/abuse: ☐ Never ☐ Currently ☐ In the past
8. Because of this spine problem, I have filed or plan to file:
   ☐ A lawsuit ☐ A Worker's Compensation claim
   ☐ Neither a lawsuit or Worker's Compensation claim

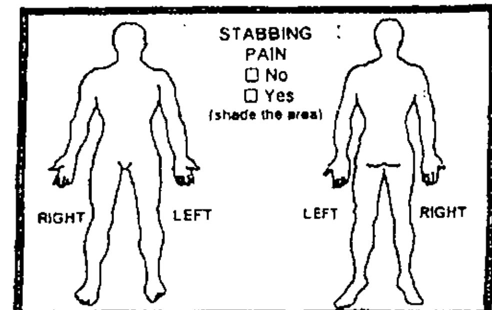






MY PAIN / DISCOMFORT IS (circle number)





____________________ Patient Signature

____________________ Date