PATIENT INFORMATION

Patient Name: ____

(Last) *(First)*

Address: ____

City: ____ State: _________________ Zip: _____________________

Home Phone (______)_________________________ Cell Phone (______)____________________________________

Cell Phone Carrier: _______________________________________

Email Address: ____

SS# ____ Sex: □ M □ F

Height: ____________ inches Weight: _____________ pounds

Birth Date: ______________________ Age: _______________

Responsible Party: □ Self □ Other (Parent, Guardian, Spouse)

If Other, Name: ____

Relation to Patient: _______________________________________

Occupation: ____

Employer: ____

Work Phone (_____)________________ # of Children ____________

□ Single □ Married □ Widowed □ Separated □ Divorced

Race: □ American Indian □ Asian □ Black or African American

□ Caucasian □ Pacific Islander □ Hispanic/Latino □ Other

Health Insurance: □ Yes □ No HSA/Flex Spending: □ Yes □ No

Insurance Name: ____

Insurance ID: _______________________ Group#: ______________

Primary Care Provider or Referring Physician:

Name:____

Address: ____

City: ____ State: _________________ Zip: _____________________

Are you under a doctor's care at the present time? □ Yes □ No

If yes, for what? ____

Name of Doctor:____

Address: ____

City: ____ State: _________________ Zip: _____________________

IN CASE OF EMERGENCY CONTACT

Name____ Phone (________)________________________________

Relation to Patient: ____

Who can we thank for referring you? If internet, what did you search for?______________________

□ Internet:
- □ Google
- □ Yelp
- □ ZocDoc
- □ Facebook
- □ Healthgrades

□ Family/Friend:______________________________

□ TV: ______________________________________

□ Mailer: ___________________________________

□ Insurance

□ Doctor

□ Other: ____________________________________

MEDICAL HISTORY ☐ None

General History (Check All That Apply)

☐ AIDS/HIV
☐ Alcoholism
☐ Allergy Shots
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Blood Transfusion
☐ Breast Lump
☐ Bronchitis
☐ Cancer
☐ Cataracts
☐ Celiac
☐ Chemical Dependency
☐ Chest pain
☐ Colitis
☐ Constipation
☐ Diabetes
☐ Diverticulosis
☐ Eating Disorder
☐ Emphysema
☐ Epilepsy
☐ Fractures
☐ Gallbladder Disorder
☐ Glaucoma
☐ Goiter
☐ Gout
☐ Heart Attack
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herniated Disk
☐ High Blood Pressure
☐ High Cholesterol
☐ Hormone Replacement Therapy
☐ Hypertension
☐ Jaundice
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Lupus
☐ Malaria
☐ Migraine Headaches
☐ Miscarriage
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Nervous Breakdown
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Pinched Nerve
☐ Pneumonia
☐ Polio
☐ Prostate Problem
☐ Prosthesis
☐ Psoriasis
☐ Psychiatric Care
☐ Rheumatoid Arthritis
☐ Rheumatic Fever
☐ STD
☐ Stroke
☐ Swelling feet
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors, Growths
☐ Ulcers
☐Vaginal Infections
☐ Whooping Cough
☐ Other:
____
____

Explanation: ____
____
____

Date of Last:
Physical Exam _______________ Spinal Exam/X-Ray_________________
MRI or CT-Scan_______________ Lab Work________________________

FAMILY HISTORY ☐ None

Possible Hereditary Diseases: ______________________________
____
____

SOCIAL HISTORY

Smoking: ☐ Every Day ☐ Occasional ☐ Former Smoker ☐ Never
Alcohol: Drinks/week_________ Caffeine: Drinks/day__________

GYNECOLOGIC HISTORY ☐ N/A

Are you currently pregnant? ☐ Yes ☐ No
Pregnancies #:________Dates:______________________________
Deliveries #_______Natural delivery or C-section? ____________
Menstrual: Onset:____________Duration: ______________
Are they regular? ☐ Yes ☐ No
Pain associated? ☐ Yes ☐ No
Last menstrual period: __________________
Check all that apply to you:
☐ Amenorrhea ☐ Heavy Periods ☐ Menopause
Fibrocystic Breast ☐ Hysterectomy ☐ Uterine Fibroma

Medications ☐ None

Medications:	***Dosages:***
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________

(Use back of sheet if additional space is needed.)

Birth Control: ____

ALLERGIES ☐ None

Medication Allergies:	***General Allergies:***
______________________________	______________________
______________________________	______________________

HOSPITALIZATIONS ☐ None

Hospitalized For:	***Date:***
______________________________	____________________
______________________________	____________________

Surgeries ☐ None

Surgery:	***Date:***
______________________________	____________________
______________________________	____________________

Do you have any surgical devices in your body? (i.e. screws, pins, plates, etc) ☐ Yes ☐ No
If yes, where are they located?_______________________________
____

ACTIVITY LEVEL

Select one of the following:

☐ Inactive: no regular physical activity with a sit-down job
☐ Light Activity: no organized physical activity during leisure time
☐ Moderate Activity: Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
☐ Heavy Activity: consistent lifting, stair climbing, heavy construction, etc. or regular participation in jogging, swimming, cycling or active sports at least three times per week.
☐ Vigorous Activity: participation in extensive physical exercise for at least 60 minutes per session, 4 or more times per week.

Patient Name: ____ *Date:* ______________________

Indicate which of the below you have experienced in the last 1-2 months:

Blank = Never; 1 = Rarely; 2 = Occasionally; 3 = Frequently; 4 = Constant

Eyes/Ears/Nose/Throat/Respiratory:				
Asthma	1	2	3	4
Stuffy Nose	1	2	3	4
Hay Fever	1	2	3	4
Sore Throat	1	2	3	4
Chronic Cough	1	2	3	4
Chest Congestion	1	2	3	4
Frequent Sneezing	1	2	3	4
Itchy/Watery Eyes	1	2	3	4
Drainage	1	2	3	4
Earache or Ear Infection	1	2	3	4
Itching	1	2	3	4
Hoarseness	1	2	3	4
Shortness of Breath	1	2	3	4
Wheezing	1	2	3	4

Muscular/Skeletal:				
Muscle Aches	1	2	3	4
Fibromyalgia	1	2	3	4
Arthritis	1	2	3	4
Joint Pain	1	2	3	4
Low Back Pain	1	2	3	4
Neck Pain	1	2	3	4
Wrist/Hand Pain	1	2	3	4
Elbow Pain	1	2	3	4
Shoulder Pain	1	2	3	4
Hip Pain	1	2	3	4
Knee Pain	1	2	3	4
Ankle/Foot Pain	1	2	3	4
Pain Between Shoulder Blades	1	2	3	4

Cardiovascular:				
Shortness of Breath with Activity	1	2	3	4
Difficulty Breathing When Lying Down	1	2	3	4

Gastrointestinal:				
Constipation	1	2	3	4
Diarrhea	1	2	3	4
Reflux or Heartburn	1	2	3	4
Bloating	1	2	3	4
Gas	1	2	3	4
Nausea or Vomiting	1	2	3	4
Chrohn's Disease	1	2	3	4
Stomach Pains or Cramping	1	2	3	4

Urinary:				
Frequency	1	2	3	4
Urgency	1	2	3	4
Burning or Pain	1	2	3	4
Blood in Urine	1	2	3	4
Incontinence	1	2	3	4

Skin:				
Rashes	1	2	3	4
Eczema	1	2	3	4
Itching	1	2	3	4
Dryness	1	2	3	4
Loss of Hair	1	2	3	4
Excessive Sweating	1	2	3	4

Neurological:				
Headaches	1	2	3	4
Migraines	1	2	3	4
Dizziness	1	2	3	4
Numbness	1	2	3	4
Tingling	1	2	3	4

Endocrine/Hormone:				
Weight Loss or Gain	1	2	3	4
Inability to Lose Weight	1	2	3	4
Hypo/Hyper Thyroid	1	2	3	4
Change in Appetite	1	2	3	4
Fatigue or Drowsiness	1	2	3	4
Poor Sleep	1	2	3	4
Decreased Endurance	1	2	3	4
Feel "Burned Out"	1	2	3	4
Hot Flashes or Night Sweats	1	2	3	4

Reproductive:				
Pain During Sex	1	2	3	4
Low Sex Drive	1	2	3	4
Erectile Dysfunction	1	2	3	4

Mental/Emotional:				
Anxiety	1	2	3	4
Stress	1	2	3	4
Depression	1	2	3	4
Poor Concentration	1	2	3	4
Foggy Thinking	1	2	3	4
Forgetfulness	1	2	3	4
Mood Swings, Irritability or Grumpiness	1	2	3	4

Other:				
Fever or Chills	1	2	3	4
Weakness	1	2	3	4
Hyperactivity	1	2	3	4
Insomnia	1	2	3	4

Which conditions/symptoms bother you the most?

How long have you been bothered by these conditions?

Describe how it feels or affects you when it is at its worst?

If you could eliminate one of the above, which would it be?

What are your health goals?

Patient Name: ______________________________ *Date:* ______________

*Patient Name*____ *DOB* ___________________ *Date* ___________________

History of Present Illness

***Please fill in each line as completely as possible.**

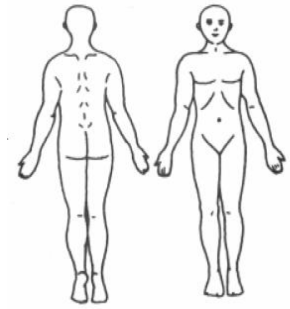
Please identify the condition(s) that brought you to this office: (If no pain or condition, initial here _______ and skip to next page)

Primary: ____ Second: ____

Third: ____ Fourth: ____

When did your condition(s) start?:____
What do you believe was the cause?____
Can it be attributed to any of the following types of accidents? □ N/A □ Automobile □ Work □ Other__________________
If yes, has it been reported to: □ Automobile Insurance □ Worker's Comp □ Lawyer □ Other _________________________

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:
Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10



Quality of the symptoms (**circle all that apply**):
Dull Achy Sore Sharp/Stabbing Burning
Numbness Tingling Swelling Other:____________________
Does it travel to any other areas? □ **No** □ **Yes** **If yes,**
Where?____

Place an "X" on the diagram → where you feel symptoms

When is the problem at its worst? ☐ AM ☐ mid-day ☐ PM ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

What makes the symptoms worse?____
What makes the symptoms better? ____
Is there a family history of this? □ **No** □ **Yes**
Are you taking any medication for this complaint? □ **Currently Yes** □ **Previously** □ **No**
If yes: □ Over the Counter □ Prescription: List here:____
Was/Is there relief of symptoms? □ **No** □ **Yes** If not currently taking, why not?________________________________
Any previous treatment for this or have been seen by previous Doctors for this? □ **No** □ **Yes**
If yes, when and with who?____
What were the treatments and/or recommendations**?** ____
Was there relief of symptoms? □ **No** □ **Yes** □ **N/A**
Anything else that has been tried to handle this on your own? □ **No** □ **Yes**
If yes, What has been tried? ____
Was there relief of symptoms? □ **No** □ **Yes**
Any prior injuries that could be related to this complaint, not already listed? □ **No** □ **Yes**
If yes, please describe:____
Any prior surgeries specifically related to this complaint? □ **No** □ **Yes**
If Yes, Please describe: ____

---Office Use Below This Line---
____
____
____
____

Provider Signature: ______________________________________ **Date: ___________________________________**

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Exercise	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
	List any specific exercises: ____			
Other: ______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: ______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: ______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Any other pertinent information about your activities? ____

Provider Signature: ______________________ Patient Name:___________________________ Date:_____________

QUADRUPLE VISUAL ANALOGUE SCALE

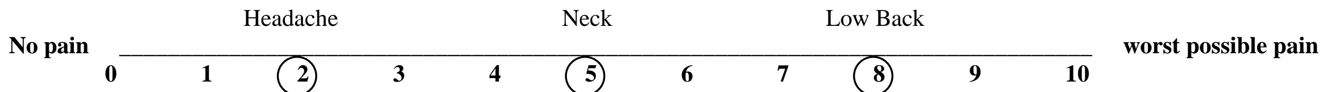
Patient Name ____ Date ___________________________

Please read carefully:

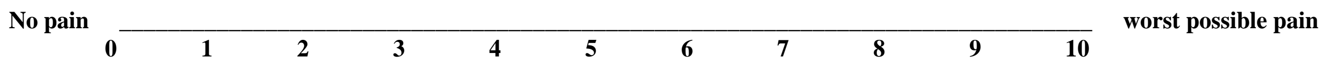
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

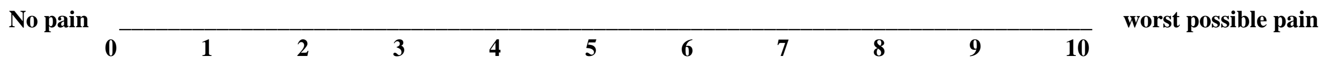
Example:



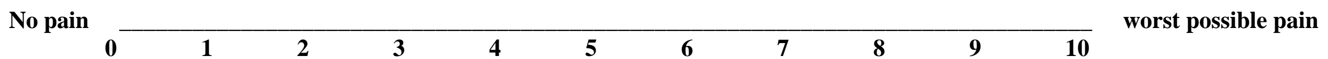
1 – What is your pain RIGHT NOW?



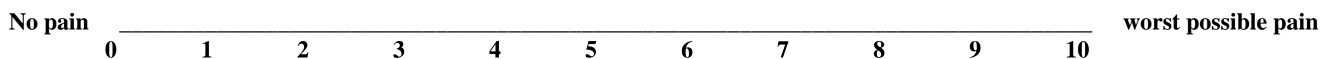
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

____

____

____
Examiner

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