Date of Visit: ____ /____ /____ **Physician:** _____

YOUR INFORMATION	
Full Name:	**Date of Birth:** ___ /___ /_____ **Age:** _____ **Height:** _____ **Weight:** _____ **Hand Dominance:** ☐ Right ☐ Left ☐ Ambidextrous
Preferred Language:	**Occupation:**
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Disabled ☐ Military	
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Life Partner	
Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other:	
Ethnicity: ☐ Hispanic ☐ Non-Hispanic	
Living Status: ☐ Lives Alone ☐ With Spouse ☐ Skilled Nursing ☐ With Other Family - Who:	
Primary Care Physician:	**Cardiologist (if applicable):**
Who referred you to us? ☐ Physician: _____ ☐ Friend: _____ ☐ Other:_____	

YOUR MEDICATIONS

☐ **No Medications** **List all the medications you take, both prescription & nonprescription below:**

Are you taking Aspirin or any other blood thinners? ☐ Yes ☐ No

Medication or Brand Name	Dose	Medication or Brand Name	Dose

YOUR ALLERGIES

☐ **No Allergies** **Indicate all the allergies you have to medications and/or food & describe reaction below:**
Common reactions include – Anaphylaxis (Life Threatening), Hives, Itching, Nausea/Vomiting, Trouble Breathing

_____

_____

YOUR PHARMACY INFORMATION

Do you have a preferred pharmacy that you use? ☐ Yes ☐ No

Pharmacy Name:	**Pharmacy Phone #:**
Street Address:	**City/State/ZIP**

YOUR PAST MEDICAL HISTORY

☐ **No Relevant Medical History**

Disease Type:	Date of Onset:	Disease Type:	Date of Onset:
☐ Hypertension	____ /____/ ____	☐ Obesity	____ /____/ ____
☐ Kidney Disease	____ /____/ ____	☐ Peripheral Vascular Disease	____ /____/ ____
☐ Heart Disease: _____	____ /____/ ____	☐ Anxiety	____ /____/ ____
☐ Diabetes – I or II	____ /____/ ____	☐ Depression	____ /____/ ____
☐ Osteoarthritis	____ /____/ ____	☐ Stroke	____ /____/ ____
☐ Osteoporosis	____ /____/ ____	☐ DVT/Blood Clots	____ /____/ ____
☐ Rheumatoid Arthritis	____ /____/ ____	☐ Ulcers	____ /____/ ____
☐ Cancer– Type: _____	____ /____/ ____	☐ AIDS/HIV	____ /____/ ____
☐ Other: _____	____ /____/ ____	☐ Other: _____	____ /____/ ____

Patient Name:_____

YOUR PAST SURGICAL HISTORY

☐ **No Surgical History**

Surgery Type:	Year of Surgery:	Surgery Type:	Year of Surgery:
☐ Appendectomy		☐ Prostate	
☐ Hysterectomy		☐ Pacemaker	
☐ Cholecystectomy		☐ Open Heart/By-Pass	
☐ Tonsillectomy		☐ Spine – Type/Level: _____	
☐ Cataracts		☐ Other: _____	

Any additional surgical information:

YOUR FAMILY HISTORY

☐ **Family History Unknown**

Mother	Father	Sister	Brother
☐ Alive & Well	☐ Alive & Well	☐ Alive & Well	☐ Alive & Well
☐ Cancer– Type: _____	☐ Cancer– Type: _____	☐ Cancer– Type: _____	☐ Cancer– Type: _____
☐ CVA/Stroke	☐ CVA/Stroke	☐ CVA/Stroke	☐ CVA/Stroke
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension
☐ Other: _____	☐ Other: _____	☐ Other: _____	☐ Other: _____

YOUR SOCIAL HISTORY

Tobacco Use: ☐ Current ☐ Former ☐ Never
Type: _____
Packs/Day: _____
Years Used: _____
Have you ever tried to quit? ☐ Yes ☐ No

Alcohol Use: ☐ Yes ☐ No ☐ Former
Type (Circle): Beer Wine Liquor
Frequency: _____
Amount per Sitting: _____
Last Drink: _____

Caffeine Use: ☐ Yes ☐ No
Type: _____
Daily Amount: _____

REVIEW OF SYSTEMS

☐ **All Negative Below** **Check if you have any of the following:**

General	Cardiovascular	Metabolic	Skin
☐ Fever	☐ Heart Murmur	☐ Cold Intolerance	☐ Rash
☐ Weakness	☐ Leg Swelling/Edema	☐ Heat Intolerance	☐ Skin Infections
☐ Weight Gain/Loss (Circle)	☐ Syncope/Fainting		☐ Skin Lesions
Ears, Nose & Vision	**Gastrointestinal (GI)**	**Neurological**	**Blood Disorders**
☐ Blurred Vision	☐ Constipation	☐ Difficulty Walking	☐ Bleeding
☐ Facial Pain	☐ Diarrhea	☐ Dizziness	☐ Bruising
☐ Headache	☐ Nausea	☐ Poor Coordination	
☐ Vertigo/Dizziness	☐ Vomiting	☐ Muscle Weakness	
Respiratory	**Urinary**	**Psychiatric**	**Immune System**
☐ Dyspnea (Difficulty Breathing)	☐ Dysuria (Difficulty Urinating)	☐ Anxiety	☐ Asthma
☐ Recent Infections	☐ Frequent Urination	☐ Depression	☐ Environmental Allergies
☐ Wheezing	☐ Hematuria (Blood in Urine)	☐ Insomnia	☐ Food Allergies

Have you been in the Emergency Room for treatment of your chronic pain? ☐ Yes ☐ No
If yes, when and how often?

Worker's Compensation Case? ☐ Yes ☐ No

Auto Accident? ☐ Yes ☐ No

Represented by Attorney? ☐ Yes ☐ No **Attorney's Name:** **Phone:**

Lawsuit Pending? ☐ Yes ☐ No **Case Manager's Name:** **Phone:**

Patient Name: _____

COMPLETE THIS BOX ***ONLY*** IF YOU WERE INVOLVED WITH AN ***AUTO*** ACCIDENT		
Were you wearing a seat belt? ☐ Yes ☐No	**Were you the driver?** ☐ Yes ☐ No	**Were you the passenger?** ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐No **If yes, for how long?**		
Briefly describe the accident: _____		
How much damage was done to your vehicle? $_____		
How long after the accident did the pain begin?		
How long after the accident did you seek medical attention?		
Did you experience pain in the same location previous to this accident? ☐ Yes ☐ No **If yes, please explain:**		

COMPLETE THIS BOX ***ONLY*** IF YOU WERE INVOLVED IN A ***WORK INJURY***
Describe injury:
How long after the incident did your pain occur?
When did you first seek medical attention? ____/_____/_____
Have you had pain in the same location prior to your work injury? ☐ Yes ☐ No **If yes, please explain:**
If it is NOT through your current employer, please list the name of the employer that it is through, along with a phone number: **Employer Name:** _____ **Phone: (___) ____-_____** **Case Manager:** _____ **Phone: (___) ____-_____**

MODIFYING FACTORS: CIRCLE THE NUMBER BELOW THAT BEST DESCRIBES THE AMOUNT OF PAIN RELIEF THAT TREATMENT IS PROVIDING OR HAS PROVIDED IN THE PAST.

	Never Tried	No Relief									Complete Relief	☑ If Receiving Now
Physical Therapy	☐	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9** **10**	☐
Surgery	☐	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9** **10**	☐
Injection/Nerve Block	☐	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9** **10**	☐
Drug/Medication Therapy	☐	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9** **10**	☐
Chiropractic Adjustment	☐	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9** **10**	☐
TENS	☐	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9** **10**	☐
Acupuncture	☐	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9** **10**	☐
Biofeedback	☐	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9** **10**	☐
Other: _____	☐	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9** **10**	☐

PLEASE INDICATE BELOW STUDIES DONE

Study	Date	Results
X-RAYS		
MRI		
EMG/Nerve Conduction Studies		
Myelogram		
Bone Scan		

DOCTORS/OTHER HEALTH PROFESSIONALS CONSULTED SINCE PAIN BEGAN

Name	Phone Number	Dates Treated

Patient Name: _____

PREVIOUS PAIN TREATMENT PROCEDURES:					
Date	**Procedure**	**Physician**	**Phone #**	**Facility Where Performed**	**Any Help?**

SUBSTANCE ABUSE:

Which of the following drugs or substances, if any, have you used in the PAST? (Please check all that apply)
☐ **Alcohol** ☐ **Cocaine** ☐ **Heroin** ☐ **IV Drugs** ☐ **Marijuana** ☐ **Other (Specify):**

Are you PRESENTLY using any of the following drugs or substances? (Please check all that apply)
☐ **Alcohol** ☐ **Cocaine** ☐ **Heroin** ☐ **IV Drugs** ☐ **Marijuana** ☐ **Other (Specify):**

YOUR ATTESTATION

I attest that the information provided above is complete & accurate as it will be utilized as part of my care and treatment plan.

Patient Signature: **Date:** ___ /___ /___

If Minor, Guardian Signature: **Date:** ___ /___ /___