PATIENT INFORMATION

Name: ____ Date of Birth: ____ /____ /____
Last First Middle

SSN: ____ Sex: F M

Address: ____

Phone: ______________ ______________ ______________
Home Work Mobile

Emergency Contact: ______________________ Relationship: ______________________

Phone: ______________ ______________ ______________
Home Work Mobile

Who referred you to our office? ____
First Last

Primary Care Physician: ____
First Last

Insurance Name/Address: ____

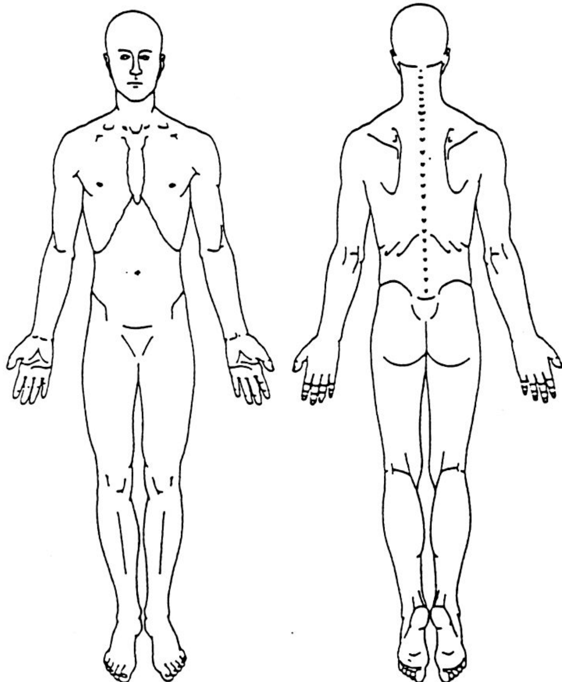
Subscriber Name: ______________________ Subscriber Date of Birth: ____ /____ /____

Occupation: ______________________ Employer: ______________________

Was your injury work related? ________ Yes ________ No ________ Not Sure Last date worked: ____ /____ /____

Claim number (if applicable): ______________________ Date of injury: ____ /____ /____

Where it hurts:



Please indicate type and location of pain using the following symbols:

Symbol	Type
///////////	Stabbing
XXXXXXX	Burning
OOOOOO	Pins and Needles
^^^^^^^	Aching/Throbbing
= = = = =	Numbness
------------	Other (please explain):

____
____
____
____

PATIENT INFORMATION

Where it hurts: (continued)

1. What activities were you engaged in when your symptoms started?

____

____

2. What time of the day are your symptoms worse?

______ Morning ______ All Day
______ Afternoon ______ Not applicable
______ Night

3. Frequency of symptoms?

______ Intermittent daily ______ During the night
______ Constant ______ Not applicable

4. What activities make the pain worse?

______ Sitting ______ Lifting ______ Climbing Stairs
______ Driving ______ Coughing/Sneezing ______ Everything
______ Walking ______ Using Arms
______ Bending ______ Standing

5. How often does the pain interrupt your sleeping?

______ Not at all ______ Often
______ Occasionally ______ Always
______ Half of the time ______ Never sleep well

6. What activities make the pain better?

____

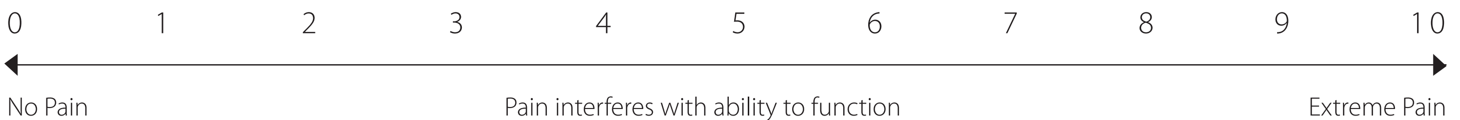
____

7. What treatments have you had for this problem? (Please Circle and Describe)

Osteopathic Chiropractic Physical Therapy Injections Bracing Traction Surgeries
Describe: ____

____

Please rate your pain today.



PATIENT INFORMATION

Social History: (Please circle one)

	Yes	No	
1. Do you use tobacco?	◯	◯	Packs or amount per week: ______
2. Do you use alcohol?	◯	◯	Consumption per week: ______
3. Do you use recreational drugs?	◯	◯	Type: ______
4. Do you have children?	◯	◯	How many: ______
5. Do you exercise?	◯	◯	____ Daily ____ Weekly ____ Rarely
6. Are you on Social Security?	◯	◯	
7. Are you on Disability?	◯	◯	
8. Martial status?			____ Married ____ Divorced ____ Widowed ____ Single ____ Other
9. Hand dominance?			____ Right ____ Left ____ Ambidextrous

Medical History:

Allergies: ______

Surgeries: ______

Have you ever had problems with general anesthesia? ____ Yes ____ No

Do you have a latex allergy? ____ Yes ____ No

History of:

Medical Condition	Self	List Relative (Mother, Father, Brother, Sister)
Heart Disease/Heart Attack		
High Blood Pressure		
Stroke		
Sugar/Diabetes		
Cancer		
Seizures/Epilepsy		
Arthritis		
Breathing/Lungs		
Stomach/Ulcer/Reflux		
Anemia/Blood		
Kidney Problems		
Hepatitis		
Parkinson's		
Multiple Sclerosis		
Thyroid (Hypo/Hyper)		
Blood Clots (DVT)		
Other		

Current Medications:

Prescription: ______

O.T.C. (Over-the-Counter): ______

PATIENT INFORMATION

Patient Name: ____________________ Date of Birth: ____ /____ /____

Constitutional
____ Fever ____ Chills ____ Weight loss/gain ____ Night sweats ____ None
____ Other ____________________

Head/Eyes
____ Headaches ____ Vision difficulty ____ Hearing difficulty ____ Dizziness ____ None
____ Other ____________________

Nose/Throat
____ Chronic congestion ____ Difficulty swallowing/speaking ____ None
____ Other ____________________

Cardiovascular
____ Irregular heart beat ____ Chest pain ____ Palpitations ____ None
____ Other ____________________

Respiratory
____ Shortness of breath ____ Chronic cough ____ None
____ Other ____________________

Genitourinary
____ Frequent urination ____ Loss of bowel/bladder ____ Urinary urgency ____ Sexual dysfunction ____ None
____ Other ____________________

Neurologic
____ Weakness/clumsiness ____ Passing out ____ Tremor ____ Seizure ____ Numbness/tingling ____ None
____ Other ____________________

Musculoskeletal
____ Back Pain ____ Difficulty walking/falls ____ Neck pain ____ Joint pain ____ None
____ Other ____________________

Gastrointestinal
____ Nausea/vomiting ____ Diarrhea ____ Constipation ____ Passing blood ____ None
____ Other ____________________

Cognitive/Psychiatric
____ Depression ____ Hallucinations (visual/auditory) ____ Confusion/memory loss ____ Language difficulty ____ None
____ Other ____________________

Integumentary (Skin)
____ Rash ____ Ulcers ____ Warmth ____ Bruising ____ None
____ Other ____________________

This section for Physician use only.

____ No Change from Initial Intake MA Initials ____________________ Date ____ /____ /____

ROS reviewed ____ Physician's Initials ____________ Date ____ /____ /____