

Today's Date ___ / ___ / ___

Primary MD:

Referred By:

CC: What problem/issue brings you here today?

HPI: How and when did it start?

What makes it *worse*? walking sitting standing lying down exercise nothing Other:

What makes it *better*? walking sitting standing lying down exercise nothing Other:

What do you want to accomplish from today's visit? Diagnosis Treatment Options X-ray MRI Meds Review Test Injection

Is this a Worker's Compensation Claim or is there litigation pending? Yes No

What diagnostic tests have you had for this problem? None X-ray MRI CT EMG Orthopedics consult

What treatments have you had? None Meds Physical therapy Chiropractor Psychotherapy Injections Surgery

Please make a *mark on the line* below to indicate the level of discomfort you have today.

No Pain _____ Worst Pain Ever
0 1 2 3 4 5 6 7 8 9 10

Please describe what the pain feels like: Achy, Burning, Cramping, Stabbing, Stiff, Tingling, Numbness, Dull, Tight, Pulling

Please describe the time course of your pain: Constant, Comes and goes, Getting worse, Getting better, Staying about the same

Medical History: Diabetes, Cancer,
High Blood Pressure, Pacemaker,
Arthritis, Osteoporosis, Other:

Surgical History:

Medications:
(Use 2nd page if needed)

Allergies to medicines:

Family History: (please include only 1st degree relatives (parents, siblings, children)) (e.g. sister, rheumatoid arthritis)
Family member: _____ **Condition:** _____

Social History:

What do you do for exercise?

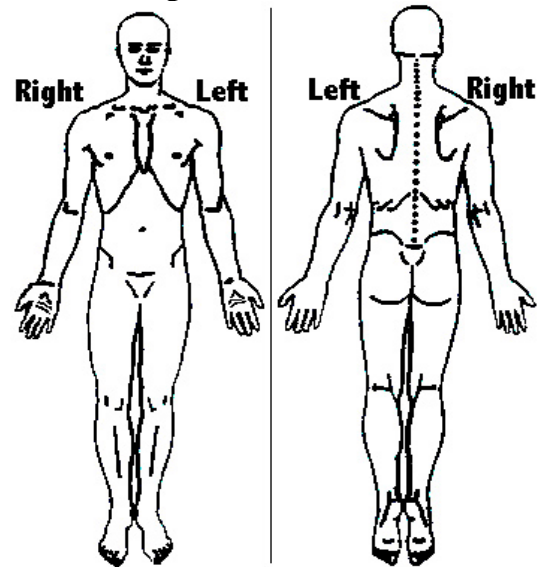
Tobacco use (cigarette, cigar, pipe, chew): Current Quit Never

Number of alcoholic beverages per week?

Occupation:

Physical requirements:	Prolonged Sitting	Prolonged Standing	Lifting	Travel	Driving	Computer	Phone	Childcare
Employment status:	Full-time	Part-time	Light Duty	Off Duty due to injury	Full-time Parent	Not working	Retired	

Please shade all locations you have pain or discomfort



Fevers, unintentional weight change?	Yes	No
Vision change, double vision?	Yes	No
Difficulty swallowing, headaches?	Yes	No
Chest pain, palpitations?	Yes	No
Shortness of breath, wheezing, cough after exercise?	Yes	No
Nausea, vomiting, black stools, loss of control of stools?	Yes	No
Loss of control of urine, urinary frequency or urgency?	Yes	No
New rashes or psoriasis or skin lesions?	Yes	No
Dizziness, weakness, numbness, tingling?	Yes	No
Depressed mood, sleep problems, anxiety?	Yes	No
Current low back pain, other joint swelling or muscle pain?	Yes	No

⊕ Are you pregnant, trying to get pregnant or breastfeeding? Yes No
⊕ Last menstrual period date: _____ Periods regular? Yes No

Patient's Signature: _____

Physician Initials/Date: _____ / _____ / _____