Patient Name: DOB:

INJURY INFORMATION

Today's visit is related to:

- ☐ Sport/Recreational Injury
- ☐ Motor Vehicle Accident Injury
- ☐ Motorcycle/Bicycle Injury
- ☐ Work Related Injury/Symptoms
- ☐ No Injury, Just Pain
- ☐ Gradual Onset
- ☐ Sudden Onset
- ☐ Other: ______________________________

If Liability, have you contacted an attorney? ☐ YES ☐ NO

If yes, attorney name/phone: ______________________________

If Work Comp, have you contacted your employer? ☐ YES ☐ NO

If yes, employer contact name/phone: ______________________________

Please describe INJURY in detail:

When did problem begin (Month/Date/Year)? ____________________ Body Part(s) (Right/Left): ______________________________

How Did Injury Occur? ______________________________

Related to your current problem:

Imaging/Study	Date	Place of Service
MRI		
CAT Scan		
X-Ray		
Bone Scan		
EMG		
Other:		

☐ None

WORK HISTORY:

☐ Presently working ☐ Disability (specify date): ____________________ ☐ Retired # of years: ____________________

If working, list employer: ______________________________ Job title: ______________________________

Hours worked per week: __________ Type of Work: ______________________________

List job duties: ______________________________

PATIENT INTAKE

Weight: ____________ Height: __________

Check the appropriate answers below:

Do you currently drink alcohol? .... ☐ Yes ☐ No If yes, how much? ______________________________

Do you currently use tobacco? .... ☐ Yes ☐ No If yes, how many packs per day? ______________________________

Are you currently taking blood thinner? .... ☐ Yes ☐ No If yes, which one? ______________________________

Are you RIGHT or LEFT hand dominant? .... ☐ Right ☐ Left

ALLERGIES

Are you allergic to any medications or latex? ☐ Yes ☐ No If yes, please list: ______________________________

Preferred Pharmacy: ______________________________

MEDICATIONS (Include prescriptions, over-the-counter medications, and vitamins.)

Please provide a list of all current medication: ☐ None

Medication	Dosage	Medication	Dosage

Are you currently under a pain contract? ☐ Yes ☐ No If yes, with whom? ______________________________

Patient Name: DOB:

MEDICAL HISTORY

SELF-MEDICAL HISTORY: (Mark only those that apply to you.)

- ☐ None Apply
- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Anemia/Bleeding Disorder/ Blood Clots
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar
- ☐ Bowel Problems (specific type): ____________________
- ☐ COPD/Bronchitis
- ☐ Cancer (specific type): ____________________
- ☐ Chest Pain (Chronic)
- ☐ Claustrophobic
- ☐ Depression
- ☐ Diabetes
- ☐ Fractured/Broken Bone (specific type & side (R/L): ____________________
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Hypothyroidism/Other Hormonal
- ☐ Immune System Problems (specific type): ____________________
- ☐ Infectious Disease (specific type): ____________________
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Mental Abuse
- ☐ Mood Disorder
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Other: ____________________
- ☐ Pacemaker
- ☐ Physical Abuse
- ☐ Schizophrenia
- ☐ Seizure Disorder
- ☐ Sexual Abuse
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Stent Placement
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Ulcer
- ☐ Women: Currently Pregnant?

SURGERY HISTORY: (Mark all surgeries that apply to you and list the year they were performed.)

- ☐ None Apply
- ☐ Appendectomy Year: _______
- ☐ Cardiac Defibrillator Year: _______
- ☐ Eye Surgery Year: _______
- ☐ Gall Bladder Year: _______
- ☐ Heart Attack Year: _______
- ☐ Heart Surgery Year: _______
- ☐ Hernia Year: _______
- ☐ Hysterectomy Year: _______
- ☐ Pacemaker Year: _______
- ☐ Spinal Surgery Year: _______
- ☐ Tonsillectomy Year: _______
- ☐ Trauma/Injury Year: _______
- ☐ Other: ___________ Year: _______
- ☐ Other: ___________ Year: _______
- ☐ Other: ___________ Year: _______

☐ Total Replacement Surgery - (Body Part(s), Specific Date(s), & Side (Right / Left)) ____________________

Past Anesthesia Reactions: ____________________

FAMILY HISTORY: (Mark only those that apply to your Mother/father. Check M for mother or F for father.)

☐ None Apply

- Alcohol Abuse (☐ M ☐ F)
- Alzheimer's Disease (☐ M ☐ F)
- Anemia/Bleeding Disorder/ Blood Clots (☐ M ☐ F)
- Anxiety (☐ M ☐ F)
- Apnea, Sleep (☐ M ☐ F)
- Arthritis (☐ M ☐ F)
- Asthma (☐ M ☐ F)
- Bipolar (☐ M ☐ F)
- Bowel Problems (specific type): ____________________ (☐ M ☐ F)
- COPD/Bronchitis (☐ M ☐ F)
- Cancer (specific type): ____________________ (☐ M ☐ F)
- Chest Pain (Chronic) (☐ M ☐ F)
- Depression (☐ M ☐ F)
- Diabetes (☐ M ☐ F)
- Gout (☐ M ☐ F)
- HIV/AIDS (☐ M ☐ F)
- Heart Disease (☐ M ☐ F)
- Hepatitis (☐ M ☐ F)
- High Cholesterol (☐ M ☐ F)
- Hypertension (☐ M ☐ F)
- Hypothyroidism/Other Hormonal (☐ M ☐ F)
- Immune System Problems (specific type): ____________________ (☐ M ☐ F)
- Infectious Disease (specific type): ____________________ (☐ M ☐ F)
- Jaundice (☐ M ☐ F)
- Kidney Disease (☐ M ☐ F)
- Mental Abuse (☐ M ☐ F)
- Mood Disorder (☐ M ☐ F)
- Osteoporosis (☐ M ☐ F)
- Other: ____________________ (☐ M ☐ F)
- Pacemaker (☐ M ☐ F)
- Physical Abuse (☐ M ☐ F)
- Schizophrenia (☐ M ☐ F)
- Seizure Disorder (☐ M ☐ F)
- Sexual Abuse (☐ M ☐ F)
- Shortness of Breath (☐ M ☐ F)
- Stent Placement (☐ M ☐ F)
- Stroke (☐ M ☐ F)
- Substance Abuse (☐ M ☐ F)
- Ulcer (☐ M ☐ F)

Please list any other information you think would be relevant to your visit with us today in the space provided below:

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