

Patient Information & Release

(Please fill out the following forms as completely as possible):

Did you hear about our program from a Past Patient? If yes, please list the person's name: _____

DEMOGRAPHIC INFORMATION:

Name: _____
(Last) (First) (M)

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ____ (____) _____ Work Phone: ____ (____) _____

E-mail: _____ Employer: _____; Type of Work/Job Title: _____

Date of Birth ____ / ____ / ____ Gender: Male Female Weight (lbs): _____ Height: _____ Marital Status (Please circle): Single / Married
Divorced / Separated / Widowed

Name and phone number of relative (not living with you) to contact in case of an emergency: _____
(Name) (Phone)

Is your condition related to: Workers' Compensation: Auto: Other: _____

If applicable, please list the name, address, phone and fax number of your Workers' Compensation or Auto Negligence attorney or firm:

(Name) (Address) (Phone #) (Fax #)

Do you use or consume any of the following: (please note NA if not applicable):

Tobacco Product(s):	YES	NO	Frequency: _____
Alcohol:	YES	NO	Frequency: _____
Illicit Drugs:	YES	NO	Frequency: _____
Caffeinated Beverage(s):	YES	NO	Frequency: _____

Please list the approximate date of your injury OR the most recent date in which your condition started bothering you: _____

REVIEWED WITH PATIENT: _____ Date: _____

Nature of Injury OR HOW DID IT START?: _____

or NO CLEAR REASON

FOR THIS EPISODE,

I have consulted with:

acupuncturist	orthopedic spine surgeon
anesthesiologist	orthopedic surgeon
cardiologist	pain specialist
chiropractor	podiatrist
company doctor	physiatrist
emergency room doctor	physical therapist
family physician	physician assistant
internist	rheumatologist
massage therapist	sports medicine doctor
neurologist	
neurosurgeon	
nurse practitioner	
OB/GYN	
occupational medicine doctor	

Other:
None of the Above

FOR THIS EPISODE,

I have had the following diagnostic tests:

Bone Scan
CT Myelogram
CT Scan
Discogram
Diagnostic Blocks
EMG
MRI
Serologic Studies
SPECT Bone Scan
SSEP
Tomogram
X-Rays

Other:
None of the Above

FOR THIS EPISODE,

I have had the following treatments:

acupuncture	massage therapy
adjustments	muscle relaxers
anti-convulsants	NSAIDS/anti-inflammatories
anti-depressants	over the counter ointments
back brace	pain medication
back education	pain patches
bed rest	physical therapy
epidural injections	
facet injections	<i>Other:</i>
IDET	<i>None of the Above</i>
home exercises/stretching	
hot/cold packs	
local injections	

SYMPTOM BEHAVIOR: *Please answer the following in relationship to how your symptoms are behaving:*

MAXIMUM TIME SITTING (before pain/symptoms worsen)	A.M.	P.M.	EVENING
MAXIMUM TIME STANDING (before pain/symptoms worsen)	A.M.	P.M.	EVENING
SITTING	INCREASES	DECREASES	REMAINS SAME
STANDING	INCREASES	DECREASES	REMAINS SAME
WALKING	INCREASES	DECREASES	REMAINS SAME
BENDING	INCREASES	DECREASES	REMAINS SAME
LIFTING	INCREASES	DECREASES	REMAINS SAME

DO YOU EXPERIENCE:

UNUSUAL BUCKLING OF KNEES?	Yes	No
UNUSUAL TRIPPING?	Yes	No
NEW HEADACHES?	Yes	No
NEW DIZZINESS?	Yes	No
UNUSUAL LIGHTHEADEDNESS?	Yes	No

REVIEWED WITH PATIENT: _____ Date: _____

PLEASE COMPLETE THE FOLLOWING HISTORY AS COMPLETELY AS POSSIBLE:

PAST MEDICAL HISTORY:

Do you have a history of or ever been diagnosed with any of the following? (Please CIRCLE all that apply):

AIDS/HIV
Abdominal Aortic Aneurysm
Anemia
Anxiety Disorder
Asthma
Cancer; type(s): _____
COPD/lung disease
CAD/coronary artery disease
Depression
Diabetes; if yes, taking insulin? _____
EKG that was abnormal? _____
Environmental Allergies
GERD/acid reflux

Hepatitis
History of Epilepsy/Seizures
History of Spine Fracture? _____
Hypercholesterolemia/high cholesterol
Hyperlipidemia
Hypertension/high blood pressure
Hypothyroidism/low thyroid
IBS/irritable bowel syndrome
Immature Skeleton (Scheuerman's)
Infection of or in the Spine
Kidney Disease
Kidney Stone(s)
Liver Disease

Metabolic Bone Disease
Migraine/Vascular Headaches
Mitral Valve Prolapse
Obesity
Osteoarthritis/OA
Osteopenia
Osteoporosis
Past Myocardial Infarction/heart attack
Peptic Ulcer Disease
Peripheral Vascular Disease
Phlebitis/blood clot(s)
Rheumatoid Arthritis/RA
Sarcoma/Multiple Myeloma
TB

Other:

Please elaborate as needed with any of the items you marked above:

Females – Are you currently or do you think you could be pregnant? Yes No

PAST SURGICAL HISTORY: Please CIRCLE all that apply; include date(s):

Appendectomy
Biopsy _____
Breast Biopsy R
Breast Biopsy L
CABG/cardiac bypass
Carpal Tunnel Release R
Carpal Tunnel Release L
Cataract Removal
Cholecystectomy/gall bladder
Coronary Artery Stent
C-section(s)
Gastric Bypass
Hemorrhoidectomy
Herniorrhaphy

Hysterectomy
Hip Replacement R
Hip Replacement L
Knee Surgery R _____
Knee Surgery L _____
Lumpectomy _____
Radical Mastectomy R
Radical Mastectomy L
Shoulder Surgery R _____
Shoulder Surgery L _____
Tubal Ligation
Tonsillectomy/T & A
Vasectomy

Cervical Fusion - level(s):
Lumbar Fusion - level(s):
Lumbar Laminectomy - level(s):
Lumbar Microdiscectomy - level(s):

Other:
None of the Above

REVIEWED WITH PATIENT: _____ Date: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION AS COMPLETELY AS POSSIBLE:

Medications: *Please list all medications, including dosages (if you know them, you are currently taking OR provide a separate list:*

Celebrex	Soma	Advil	Fish Oil
Flexeril	Tylenol with Codeine	Aleve	Multivitamins
Lyrica	Ultram	Aspirin	NSAIDS
Motrin	Valium	Excedrin	
Naprosyn	Vicodin	Glucosamine Chondroitin	Other:
Neurontin	Zanaflex	Ibuprofen OTC	None
Norco		Lidocaine Patch	
NSAIDS/Anti-inflammatories		Motrin OTC	
Oral Steroids		Nuprin	
Oxycontin		Tylenol	
Percocet		Tylenol Arthritis	
Percodan			
Skelaxin			

Allergies/Sensitivities:

Amoxicillin	Latex	Other:
Cephalosporins	Peanuts/nuts	None:
Codeine	Perfumes	
Darvocet	Rubbing Alcohol	
Iodine	Scented lotions/creams	
Penicillin	Tape	
Radiographic Dyes		
Sulfa		
Tetracycline		

Do you have any other medical conditions not previously mentioned? _____ **yes** _____ **no** **If yes, please explain:** _____

When was your last physical examination ? _____

Please list any other pertinent information that might be valuable before reviewing your injury and/or prescribing proper treatment: _____

REVIEWED WITH PATIENT: _____ Date: _____

October 2011

PATIENT PHYSICIAN INFORMATION

Please note to which physician you would like us to send your notes by placing a (*) in front of his or her name:

FAMILY PHYSICIAN:

If applicable, please complete the following:

Physician Name: _____ Office Number: _____ Fax Number: _____
Address: _____ City: _____ State: _____ Zip Code: _____

CARDIOLOGIST:

If applicable, please complete the following:

Physician Name: _____ Office Number: _____ Fax Number: _____
Address: _____ City: _____ State: _____ Zip Code: _____

OTHER SPECIALIST:

If applicable, please complete the following:

Physician Name: _____ Office Number: _____ Fax Number: _____
Address: _____ City: _____ State: _____ Zip Code: _____

OTHER SPECIALIST:

If applicable, please complete the following:

Physician Name: _____ Office Number: _____ Fax Number: _____
Address: _____ City: _____ State: _____ Zip Code: _____

REVIEWED WITH PATIENT: _____ Date: _____

REVIEW OF SYSTEMS

Please circle those symptoms that apply to you OR check the NO box:

- GENERAL No Yes unintentional weight changes (loss or gain), fever, chills, sweats, fatigue
- EYES No Yes visual changes, excessive tearing, eye discharge, eye pain or redness, light intolerance
- EARS, NOSE, MOUTH
THROAT No Yes hearing loss; ear, nose, mouth or throat discharge, sore throat, hoarseness, ringing in the ears
- HEME/LYMPHATIC No Yes lumps in neck, under the arms or in the groin; abnormal bleeding or bruising
- SKIN No Yes rash, itching, bruising, discoloration, pigmentation changes, change in skin texture, hair or nails, psoriasis
- ALLERGIC (or
autoimmune) No Yes environmental allergies; medication allergies
- RESPIRATORY No Yes shortness of breath, cough, change in breathing pattern
- CARDIOVASCULAR No Yes chest pain, heart palpitations, edema (swelling)
- GASTROINTESTINAL No Yes nausea, difficulty swallowing, bowel function changes, abdominal pain, diarrhea, constipation, heartburn, vomiting, change in stool color or consistency, food intolerance, rectal pain, Crohn's disease, ulcerative colitis, incontinence of stool
- GENITOURINARY No Yes difficulty with bladder control, unusual itching or discharge, lesions of the genitalia, genital pain, menstrual pain, urinary tract infection, incontinence of urine
- ENDOCRINE No Yes excessive hunger, excessive thirst, appetite changes, heat or cold intolerance, history of Grave's disease, Hypothyroidism, diabetes
- PSYCHIATRIC No Yes depression, anxiety, unusual mood changes, hallucinations, schizophrenia
- MUSCULOSKELETAL No Yes joint or muscle pain or swelling, joint deformity, extremity weakness or paralysis, cramping or muscle spasms, Rheumatoid arthritis, osteoarthritis, fractures
- NEUROLOGIC No Yes numbness, tingling, pins and needles sensation, dizziness, blackouts, tremors, memory loss, speech impediment, unsteady gait, disorientation

REVIEWED WITH PATIENT: _____ Date: _____

October 2011