

# 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)

### Do you use or consume any of the following:

<b>Tobacco Product(s):</b>	<b>YES</b>	<b>NO</b>	<b>Type:</b> _____
<b>Alcohol:</b>	<b>YES</b>	<b>NO</b>	<b>Type:</b> _____
<b>Illicit Drugs: Type(s):</b>	<b>YES</b>	<b>NO</b>	<b>Type:</b> _____
<b>Caffeinated Beverage(s):</b>	<b>YES</b>	<b>NO</b>	<b>Type:</b> _____

**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 #)

REVIEWED WITH PATIENT: \_\_\_\_\_ Date: \_\_\_\_\_

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

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
chiropractor	pain specialist
company doctor	podiatrist
emergency room physician	physiatrist
family physician	physical therapist
internist	physician assistant
massage therapist	rheumatologist
neurologist	sports medicine doctor
neurosurgeon	
nurse practitioner	
occupational medicine doctor	
OB/Gyn	

***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:***

accupuncture  
 adjustments  
 anti-convulsants  
 anti-depressants  
 back brace  
 back education  
 bed rest  
 epidural injections  
 facet injections  
 IDET  
 home exercises/stretching  
 hot/cold packs  
 local injections  
 massage therapy  
 muscle relaxants  
 NSAIDS/anti-inflammatories

***Other:***

*None of the Above*

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

BEST TIME OF DAY: MORNING AFTERNOON EVENING

WORST TIME OF DAY: MORNING AFTERNOON EVENING

MAXIMUM TIME SITTING: \_\_\_\_\_ MINUTES HOURS

MAXIMUM TIME STANDING: \_\_\_\_\_ MINUTES HOURS

<i>SITTING:</i>	INCREASES	DECREASES	REMAINS SAME
<i>STANDING:</i>	INCREASES	DECREASES	REMAINS SAME
<i>WALKING:</i>	INCREASES	DECREASES	REMAINS SAME
<i>BENDING:</i>	INCREASES	DECREASES	REMAINS SAME
<i>LIFTING:</i>	INCREASES	DECREASES	REMAINS SAME

**UNUSUAL BUCKLING OF KNEES?** Yes No

**UNUSUAL TRIPPING ON TOES?** Yes No

**UNUSUAL DIZZINESS?** Yes No

**UNUSUAL LIGHTEADEDNESS?** Yes No

REVIEWED WITH PATIENT: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING IN REGARD TO YOUR MEDICAL HISTORY:**

**Do you have any of the following medical conditions: (please circle the appropriate answer and elaborate as needed)**

<b>CARDIAC OR HEART PROBLEMS?</b>	<b>NO</b>	<b>YES</b>	_____
<b>HIGH BLOOD PRESSURE?</b>	<b>NO</b>	<b>YES</b>	_____
<b>HISTORY OF HEART ATTACK?</b>	<b>NO</b>	<b>YES</b>	_____
<b>HISTORY CHEST PAIN(S)?</b>	<b>NO</b>	<b>YES</b>	_____
<b>HISTORY OF BLOOD CLOT?</b>	<b>NO</b>	<b>YES</b>	_____
<b>LUNG OR BREATHING PROBLEMS?</b>	<b>NO</b>	<b>YES</b>	_____
<b>ASTHMA?</b>	<b>NO</b>	<b>YES</b>	_____
<b>HISTORY OF CANCER? WHERE?</b>	<b>NO</b>	<b>YES</b>	_____
<b>HISTORY OF FRACTURE? WHERE?</b>	<b>NO</b>	<b>YES</b>	_____
<b>SPINE INFECTION? WHEN?</b>	<b>NO</b>	<b>YES</b>	_____
<b>DIABETES?</b>	<b>NO</b>	<b>YES</b>	_____
<b>HIGH CHOLESTEROL?</b>	<b>NO</b>	<b>YES</b>	_____
<b>ARTHRITIS?</b>	<b>NO</b>	<b>YES</b>	_____
<b>OSTEOPOROSIS?</b>	<b>NO</b>	<b>YES</b>	_____
<b>BONE DISEASE?</b>	<b>NO</b>	<b>YES</b>	_____
<b>HEADACHES/MIGRAINES?</b>	<b>NO</b>	<b>YES</b>	_____
<b>HISTORY OF SEIZURES?</b>	<b>NO</b>	<b>YES</b>	_____
<b>UNUSUAL WEIGHT CHANGE?</b>	<b>NO</b>	<b>YES</b>	_____

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

REVIEWED WITH PATIENT: \_\_\_\_\_ Date: \_\_\_\_\_

**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:**

**PLEASE COMPLETE THE FOLLOWING INFORMATION AS COMPLETELY AS POSSIBLE:**

**Medications:** *Please circle all medications you are currently taking OR provide a separate list:*

Celebrex  
Darvocet  
Flexeril  
Lyrica  
Motrin  
Naproxen/Naprosyn  
Neurontin  
Norco  
Oxycontin  
Percocet  
Percodan  
Skelaxin

Soma  
Tylenol with Codeine  
Ultram  
Vicodin  
Zanaflex

Advil  
Aleve  
Aspirin  
Excedrin  
Glucosamine Chondroitin  
Ibuprofen OTC  
Lidocaine Patch  
Motrin OTC  
Nuprin  
Tylenol  
Tylenol Arthritis

Fish Oil  
Multivitamins  
NSAIDS  
**Other:**  
**None of the Above**

**Allergies/Sensitivities:**

Amoxicillin  
Cephalosporins  
Codeine  
Darvocet  
Penicillin

Latex  
Peanuts/nuts  
Rubbing Alcohol  
Scented lotions/creams  
Tape

Radiographic Dyes  
Sulfa  
Tetracycline  
Perfumes

**Other:**  
**None of the Above**

REVIEWED WITH PATIENT: \_\_\_\_\_ Date: \_\_\_\_\_

October 2011

Do you have any other medical conditions not previously mentioned?  Yes  No If yes, please explain: \_\_\_\_\_

**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: \_\_\_\_\_