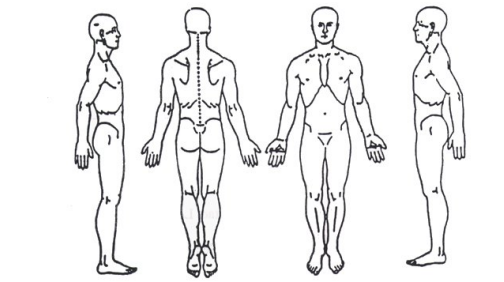
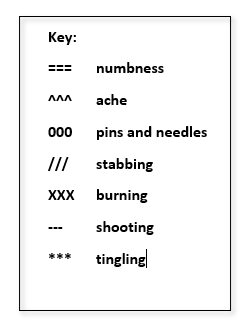
Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: ❑F ❑ M

Hand Dominance: ❑ R ❑L Height (feet, inches): \_\_\_\_\_\_\_\_\_ Weight (lbs.) \_\_\_\_\_\_\_\_

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe how your illness or pain began, include date(s) if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please use the key symbols to mark where you feel that type of sensation on the body:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Is there anything that makes your pain/symptoms WORSE? | | | | Is there anything that makes your pain/symptoms BETTER? | | | |
| Check box (X) that describes: | 0 None | 1-2 Mild | 3-4 Uncomfortable | | 5-6 Distressing (fairly 5-6severe) | 7-8 Very Severe (horrible) | 9-10 Unbearable (excruciating) |
| Pain as it usually feels | ❑ | ❑ | ❑ | | ❑ | ❑ | ❑ |
| Pain at its worse | ❑ | ❑ | ❑ | | ❑ | ❑ | ❑ |
| Pain at its least or no pain | ❑ | ❑ | ❑ | | ❑ | ❑ | ❑ |
| How many days a week do you experience pain? ❑ Daily ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ Intermittent | | | | | | | |

|  |  |
| --- | --- |
| **Have you had any of the following treatments**  **or testing for your conditions?** (Check all that apply) | |
| ❑ Surgery Date(s)? | ❑ Injections Date or last injection?  What was injected? |
| ❑ Chiropractic or Osteopathic Adjustments | ❑ Physical Therapy |
| ❑ Acupuncture | ❑ Massage |
| ❑ Prescription Medication | ❑ OTC Medication (e.g., ibuprofen, acetaminophen) |
| ❑ X-ray | ❑ MRI |
| ❑ Ultrasound | ❑ CT |
| ❑ EMG/NCV | ❑ Other: |

|  |  |  |
| --- | --- | --- |
| **In the *past month*, have you had any of the following problems?** | | |
|  | | |
| **General** | **NERVOUS SYSTEM** | **EYES** |
| ❑ Unplanned weight change | ❑ Headaches | ❑ Blurred vision |
| ❑ Fatigue | ❑ Dizziness | ❑ Loss of vision |
| ❑ Weakness | ❑ Fainting or loss of consciousness | ❑ Double vision |
| ❑ Fever | ❑ Numbness or tingling |  |
| ❑ Night sweats | ❑ Memory loss | **KIDNEY/URINE/BLADDER** |
|  | ❑ Seizures | ❑ Frequent or painful urination |
| **Muscle/Joints/Bones** | ❑ Paralysis | ❑ Blood in urine |
| ❑ Numbness |  | ❑ Incontinence |
| ❑ Joint pain | **STOMACH AND INTESTINES** | ❑ Urgency |
| ❑ Muscle weakness | ❑ Nausea |  |
| ❑ Loss of Motion | ❑ Heartburn | **PSYCHIATRIC** |
| ❑ Stiffness | ❑ Stomach pain | ❑ Depression |
|  | ❑ Vomiting | ❑ Excessive worries |
| **ENT** | ❑ Persistent diarrhea | ❑ Change in sleep pattern |
| ❑ Ringing in ears | ❑ Black or bloody stools | ❑ Thoughts of suicide / attempts |
| ❑ Loss of hearing |  | ❑ Stress |
| ❑ Difficulty swallowing | **SKIN** | ❑ Irritability |
| ❑ Pain in jaw | ❑ Redness | ❑ Hallucinations |
| ❑ Sore throat | ❑ Rash | ❑ Nervousness |
|  | ❑ Nodules/bumps | ❑ Mood swings |
| **HEART AND LUNGS** | ❑ Hair loss | ❑ Anxiety |
| ❑ Chest pain | ❑ Color changes of hands or feet |  |
| ❑ Palpitations |  | **OTHER PROBLEMS:** |
| ❑ Shortness of breath | **BLOOD** | ­­­­­­­­­­­­­­­­ |
| ❑ Wheezing | ❑ Bruising | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ❑ Swollen legs or feet | ❑ Bleeding |  |
| ❑ Cough | ❑ Clots | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Family History** | ❑ Arthritis (any type) | ❑ Cancer | | ❑ Diabetes |
| ❑ Heart Problems | ❑ Osteoporosis | | ❑ Stroke |
| ❑ No family history of medical problems | | ❑ Other: | |

|  |
| --- |
| **Pharmacy Information** |
| Pharmacy Name: |
| Pharmacy Address: |
| Pharmacy Phone #: |

**Allergies:** List all medication, environmental, food, or chemical allergies and type of reaction ❑ No allergies

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescription Medications:** ❑ None

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**Over the Counter Medications, Supplements, Vitamins, Creams, Eye Drops, Oils, or Others** ❑ None

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| --- | --- | --- | --- |
| **Past medical history** ❑ None  Do you now or have you ever had: | | | |
| ❑ Anemia | ❑ Deep Vein Thrombosis | ❑ Heart Murmur | ❑ Pulmonary Hypertension |
| ❑ Arthritis (Rheumatoid/Osteoarthritis) | ❑ Diabetes | ❑ Hepatitis | ❑ Seizures |
| ❑ Asthma | ❑ Folic Acid Deficiency | ❑ High Blood Pressure | ❑ Sleep Apnea |
| ❑ Bleeding Disorder | ❑ Gout | ❑ HIV/AIDS | ❑ Stroke |
| ❑ Cancer | ❑ Heart Attack | ❑ Low Platelet Count | ❑ Thyroid Disease |
| ❑ COPD | ❑ Heart Arrhythmia | ❑ Osteoporosis/Osteopenia | ❑ Vitamin B12 Deficiency |
| ❑ Other (Please list) | | | |

**Injuries:** Automobile accident, fractures, strains, sprains, concussion, any other ❑ No injuries

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries:** Please include dates ❑ No surgeries

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Have you had any adverse reactions to local anesthetics? (e.g., Novocain, lidocaine)

❑ Yes ❑ No ❑ Unknown What was your reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any adverse reactions to sedation?

❑ Yes ❑ No ❑ Unknown What was your reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any implanted medical devices or prosthetics?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Social History** | Occupation: | | | |
| Marital Status: | ❑ Single ❑Married ❑ Divorced ❑ Widowed ❑ Other | | |
| Do you exercise? | | ❑ Yes ❑ No | If yes, what type and how often? |
| Do you us tobacco? | | ❑ Yes ❑ No | If yes, how often? |
| Do you use alcohol? | | ❑ Yes ❑ No | If yes, how often? |
| Do you use recreational drugs? | | ❑ Yes ❑ No | If yes, how often? |
| What are your interests or hobbies? | | | |

❑ Yes ❑ No *If yes, please provide a copy of your* ***“Medical Identification Card”*** *or provide the following information:*

Device Name or Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Model Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Implantation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_