

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Are You Right Handed  Left Handed   
 Referring Physician \_\_\_\_\_ May we release medical information to this doctor? Yes  No   
 Primary Physician (If different from above) \_\_\_\_\_ May we release medical information to this doctor? Yes  No   
 Is your current problem as a result of: (check all that apply) Date of Injury \_\_\_\_\_  
 Car accident  Work accident  Other accident  Referral for litigation purposes

Describe your current problem: \_\_\_\_\_  
 How and when did your problem begin? \_\_\_\_\_  
 Where is your pain? \_\_\_\_\_  
 Describe your pain. Throbbing? Knifelike? Sharp? Dull? \_\_\_\_\_  
 How often is this occurring? \_\_\_\_\_  
 What type of treatment have you received? Therapy? Medications? \_\_\_\_\_

If you are allergic to any medications, please list; if none, please write "none." \_\_\_\_\_

Please list medications you are currently taking, if none, please write "none." \_\_\_\_\_

Are you having or have you had any problems with your: (Circle Yes or No)

Eyes	Yes	No	Anxiety/Depression	Yes	No	Bladder	Yes	No
Ears, Nose, Throat	Yes	No	Nervous System	Yes	No	Digestion/Stomach	Yes	No
Lungs, Breathing	Yes	No	Skin/Breast	Yes	No	Bowel Movement	Yes	No
Heart	Yes	No	Immunity/Allergies	Yes	No	Blood/Lymph	Yes	No
Kidneys	Yes	No	Brain	Yes	No	Numbness/Tingling	Yes	No

Have you ever been diagnosed with: (Explain your yes answers)

Diabetes	Yes	No	_____	Heart Disease	Yes	No	_____
High Blood Pressure	Yes	No	_____	TB	Yes	No	_____
AIDS	Yes	No	_____	Epilepsy/Seizures	Yes	No	_____
Cancer	Yes	No	_____	Polio	Yes	No	_____
Arthritis	Yes	No	_____	Psychiatric Illness	Yes	No	_____
Stroke	Yes	No	_____	Peptic Ulcer Disease	Yes	No	_____
Other	_____						

Have you ever had general anesthesia: Yes No Have you ever had any problems with general anesthesia? Yes No  
 If Yes, Describe: \_\_\_\_\_

Surgery/Approximate Date, If none, please write "none." _____	Physician _____
_____	_____
_____	_____

Please answer whether or not your family member is alive and what is his/her age, health, or cause of death.

Living	Age/Health status/cause of death:	Living	Age/Health status/cause of death:
Father Yes No _____	Sister/Brother Yes No _____	Sister/Brother Yes No _____	Sister/Brother Yes No _____
Mother Yes No _____			

Employment and nature of your job: \_\_\_\_\_  
 Your Marital Status: S M W D Number of Children: \_\_\_\_\_  
 Do you smoke? Yes No Number of packs per day \_\_\_\_\_ How long? \_\_\_\_\_  
 Consume alcohol: Yes No How Much? \_\_\_\_\_ How Often? \_\_\_\_\_  
 History of substance abuse? Yes No What? \_\_\_\_\_ Treatment? \_\_\_\_\_  
 Do you exercise? Yes No What kind? \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_

(Parent if patient is a minor)  
**Patient Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

Reviewed by: \_\_\_\_\_ / / \_\_\_\_\_ / / \_\_\_\_\_ / / \_\_\_\_\_ / / \_\_\_\_\_ / /