

Name: _____

Date: _____

Chief Complaint: _____

When did problem begin: _____ Which side: Right Left

How did the pain begin: _____ Does it wake you at night: Yes No

What makes the pain worse: _____

What makes the pain better: _____

Have you had any (circle): X-rays MRI CT scan BoneScan EMG Mylelogram Other: _____

When: _____ Where: _____ Ordered by: _____

Have you had Physical Therapy: Yes No Are you still working: Yes No Light Duty

Medical History: (continue on back if needed)

Medical Problems: _____

Please list all medications, vitamins, OTC pain relievers, or other any other substance taken on a regular basis

Drug, Tape or Dye Allergies: _____

Previous Surgeries: _____

Have you ever had a blood transfusion? Yes No

Family/Social History

Does anyone in your family have a history of: (circle)

- Heart disease Diabetes Arthritis Stroke
- Kidney trouble Muscular disease Mental Illness Anesthetic complications
- Substance Abuse Cancer (please specify): _____

Parent's age and health (if deceased: age at death and cause): _____

Do you smoke? Yes No How much? _____ Do you drink? Yes No How much? _____

How many children?

Females: Is there any possibility you are pregnant? Yes No

Are you experiencing any of the following? (circle)

- Fever Weight Loss Vision problems Sinusitis
- Dizziness Heart disease Chest pain High blood pressure
- Asthma Lung problems Cough Liver problems
- Dark urine Appetite loss Ulcers Kidney problems
- Scoliosis Diabetes Gout Arthritis
- Stroke Rashes Skin Cancer Seizures
- Depression Sleep problems Sexual problems Infectious Diseases
- Other _____