NEW PATIENT INFORMATION FORM

PATIENT NAME: _____AGE:_____D ATE: _____

HISTORY: CHIEF COMPLAINT (the reason for the doctor visit today) _____

Where is the pain/problem: _____

Describe what kind of pain (circle): (Burning, Sharp, Dull, Ache, Throbbing, On/Off or Constant);

_____

How severe is the pain/problem on a pain scale from 1-10, with 10 being the worst pain ever felt?

Pain Scale

How long have you had this pain/problem or when did it start?_____, has it gotten worse?_____Better_____
In the past _____weeks, months, years.

What makes it feel better? (Circle) : (Rest, Sitting, Standing, Walking, Lying down, Heat, Medications)

What makes if feel worse? (circle): (Rest, Sitting, Standing, Walking, Lying down, Bending, Lifting, Getting up from seated position, Climbing stairs.)

Where were you when the pain started? Was it gradual, sudden onset or present for many years?)

_____

Associated symptoms (circle): (Tingling, Numbness, Swelling, Weakness, Balance, Walking Problem, Incontinence)
_____

TREAMENT HISTORY: For this condition (for chief complaint above)(circle):

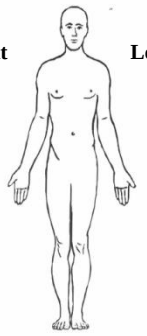
X-ray: NO/YES	MRI: NO/YES	PHYSICAL THERAPY: NO/YES
Neurologist/EMG: NO/YES	Chiropractor: NO/YES	Spine Surgeon: NO/YES
Pain Medication: NO/YES	Epidural Injections: NO/YES	Local Injections: NO/YES

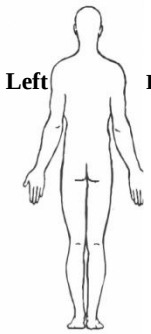
MEDICAL HISTORY

Primary Care Physician: _____

Patients Medical History

Diabetes:	NO/YES
High Blood Pressure:	NO/YES
Cancer:	NO/YES
Stroke:	NO/YES
Heart Trouble:	NO/YES
Arthritis/Gout:	NO/YES
Bleeding Tendency:	NO/YES
High Cholesterol:	NO/YES
Other:	_____





Previous Hospitalization/Surgeries/Injuries
_____
_____

Medications
_____
_____

Patient Personal/Social History (circle)
Handedness: Left/Right Marital Status: Single/Married/Separated/Divorced/Widowed
Use of Alcohol: Never/Rarely/Moderate/Daily
Use of Tobacco: Never/Previously, But quit/Current Packs/Day

Employment Title: _____Job Description: _____

Family Medical History:
Father's Age: _____ Diseases: _____If deceased, cause of death _____
Mother's Age _____ Diseases: _____If deceased, cause of death _____

REVIEW OF SYSTEMS

HEIGHT: _____

WEIGHT: _____

Injury Symptoms
Motor vehicle or other Injury Describe:
_____

Seat Belted	NO	YES
Rear Ended/Whiplash	NO	YES
Lawsuit Pending	NO	YES
Currently Employed	NO	YES

Current Source of Income _____

Constitutional Symptoms

Good General Health	NO	YES
Recent Weight Change	NO	YES
Fever	NO	YES
Fatigue	NO	YES
Headaches	NO	YES

Cardiovascular

Heart Trouble	NO	YES
Chest Pain/Angina	NO	YES
Shortness of Breath	NO	YES
Swelling of Feet/Ankles/Hands	NO	YES

Respiratory

Chronic or Frequent Coughs	NO	YES
Shortness of Breath	NO	YES
Asthma/Wheezing	NO	YES

Gastrointestinal

	NO	YES
Loss of Appetite	NO	YES
Change in Bowel Habits	NO	YES
Nausea or Vomiting	NO	YES
Constipation	NO	YES
Abdominal Pain/Heartburn	NO	YES
Peptic Ulcer	NO	YES

Genitourinary

	NO	YES
Frequent Urination	NO	YES
Burning or Painful Urination	NO	YES
Blood in Urine	NO	YES
Difficulty Starting/Stopping	NO	YES
Incontinence	NO	YES
Sexual Difficulty	NO	YES
Female-Vaginal Discharge	NO	YES

Musculoskeletal

Joint Pain	NO	YES
Joint Stiffness/Swelling	NO	YES
Weakness of Muscles or Joints	NO	YES
Muscle Pain or Cramps	NO	YES
Back Pain	NO	YES
Neck Pain	NO	YES
Difficulty in Walking	NO	YES

Neurological

Frequent or Recurring Headache	NO	YES
Light Headed or Dizzy	NO	YES
Convulsions or Seizures	NO	YES
Numbness or Tingling Sensations	NO	YES
Tremors	NO	YES
Paralysis	NO	YES
Head Injury	NO	YES

Psychiatric

Memory Loss or Confusion	NO	YES
Nervousness	NO	YES
Insomnia	NO	YES

Endocrine

Glandular or Hormone Problem	NO	YES
Thyroid Disease	NO	YES
Excessive Thirst or Urination	NO	YES
Heat or Cold Intolerance	NO	YES

*Allergic/Immunologic
(History of skin reaction or other adverse reaction to)

Penicillin or Other Antibiotics	NO	YES
Morphine, Demerol, Narcotics	NO	YES
Novocaine or Anesthesia	NO	YES
Aspirin or Other Pain Remedies	NO	YES

Other Drugs or Foods: List Name:_____
_____

Work Compensation	NO	YES
No Fault	NO	YES

Notes:

DOCTOR SIGNATURE: _____