

Date: _____

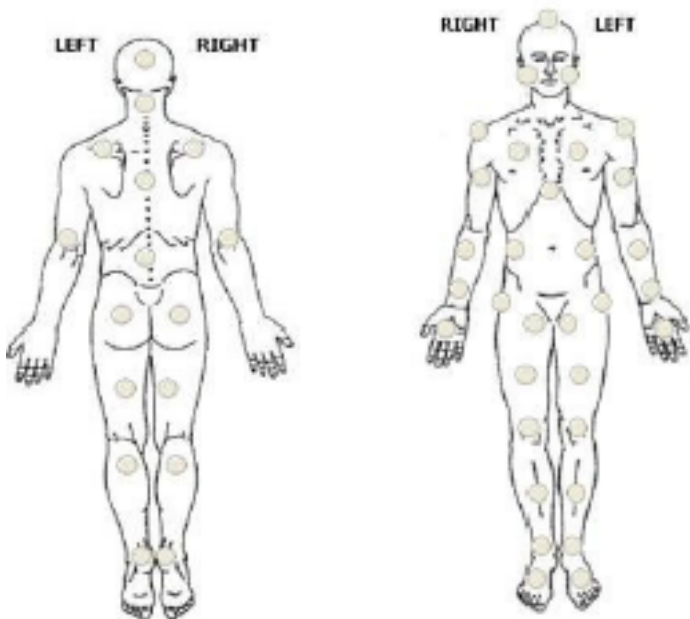
New Patient



LAST NAME: _____ FIRST NAME: _____ MI: _____

DOB: _____ Email: _____

Details of Issues: _____



Please place an X on one part of the body where you are Experiencing pain or discomfort.

List your complaints in the order of severity. Using 1,2....

If you do not see your complaint on the picture please list the complain on the other line.

Other: _____

INITIAL EVALUATION – Non Accident Related



What brings you into our office? **Not accident related**

Do you feel your condition is: Improving Staying the same Getting worse

Have you lost time from work? Yes No

Can you perform physical work activities? Yes No

If no, because of: Pain Weakness Stress

Can you go to sleep without problems? Yes No

Do you awaken because of pain? Yes No

Did you have sleep problems before? Yes No

Activities of Daily Living

Please select **all** activities which you are currently experiencing problems:

- | | | | | | |
|------------------------------------|--|-------------------------------------|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Tasting | <input type="checkbox"/> Smelling | <input type="checkbox"/> Eating | <input type="checkbox"/> Hearing | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Reading | <input type="checkbox"/> Typing | <input type="checkbox"/> Writing | <input type="checkbox"/> Grasping | <input type="checkbox"/> Using the toilet |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Leaning | <input type="checkbox"/> Walking | <input type="checkbox"/> Stooping | <input type="checkbox"/> Squatting | <input type="checkbox"/> Loss of sexual drive |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Twisting | <input type="checkbox"/> Carrying | <input type="checkbox"/> Lifting | <input type="checkbox"/> Pushing | <input type="checkbox"/> Restful sleeping |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Driving | <input type="checkbox"/> Sports | <input type="checkbox"/> Exercising | <input type="checkbox"/> Reclining | <input type="checkbox"/> Loss of concentration |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Riding in car | <input type="checkbox"/> Air travel | <input type="checkbox"/> Climbing | <input type="checkbox"/> Pulling | <input type="checkbox"/> Changes in personality |
| <input type="checkbox"/> Grooming | <input type="checkbox"/> Pinching | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Reaching | <input type="checkbox"/> Nervous | <input type="checkbox"/> Tactile feeling |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Holding | | | | |

INITIAL EVALUATION – Non Accident Related



Past Medical History

Please select all conditions that you have had or are currently having:

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Aortic aneurysm | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Breast soreness | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiovascular Dx | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Chronic sinusitis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Convulsions | <input type="checkbox"/> COPD | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dermatitis, Eczema/Rash | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty in swallowing | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Fainting | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> General fatigue | <input type="checkbox"/> Gout | <input type="checkbox"/> Hand pain | <input type="checkbox"/> Headache | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> High PSA | <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Irregular menstrual flow | <input type="checkbox"/> Irritable colon |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Kidney disorders | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Liver / Gallbladder Problems | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Loss of bladder control | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Mental Disease | <input type="checkbox"/> Mid back pain |
| <input type="checkbox"/> Muscular in coordination | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Pain in ankle or foot | <input type="checkbox"/> Pain in lower leg or knee |
| <input type="checkbox"/> Pain in upper arm or elbow | <input type="checkbox"/> Pain in upper leg and hip | <input type="checkbox"/> Painful urination | <input type="checkbox"/> PMS | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Profuse menstrual flow | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Renal disease | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling/stiffness joints | <input type="checkbox"/> Thyroid disease of |
| <input type="checkbox"/> Tinnitus/ear noises | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumor | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Wrist pain | | | | |

INITIAL EVALUATION – Non Accident Related



Family History

Please select all conditions that run in your family:

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Weight Gain/loss | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Aortic aneurysm | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Breast soreness | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiovascular Dx | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Chronic Sinusitis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Convulsions | <input type="checkbox"/> COPD | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dermatitis,
Eczema/Rash | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty
swallowing | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Fainting | <input type="checkbox"/> Frequent
urination |
| <input type="checkbox"/> General fatigue | <input type="checkbox"/> Gout | <input type="checkbox"/> Hand pain | <input type="checkbox"/> Headache | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HBP | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> High PSA | <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Irregular
menstrual flow | <input type="checkbox"/> Irritable colon |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Kidney disorders | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Liver/Gallbladder
problems | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Loss of bladder
control | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Mental disease | <input type="checkbox"/> Mid back pain |
| <input type="checkbox"/> Muscular
coordination | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Pain in ankle or
foot | <input type="checkbox"/> Pain in lower leg
or knee |
| <input type="checkbox"/> Pain in upper
arm or elbow | <input type="checkbox"/> Pain in upper leg
and hip | <input type="checkbox"/> Painful urination | <input type="checkbox"/> PMS | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Profuse menstrual
flow | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Renal Dx | <input type="checkbox"/> Rheumatoid
arthritis |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling/stiffness
of joints | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Tinnitus/
ear noises | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumor | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Visual
disturbances |
| <input type="checkbox"/> Wrist pain | | | | |

INITIAL EVALUATION – Non Accident Related



Surgical History

Please select all surgeries that you have had in the past.

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Abdominal Exploration | <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Abortion |
| <input type="checkbox"/> ACL Reconstruction | <input type="checkbox"/> Adenoid Removal | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Bone Fracture Repair |
| <input type="checkbox"/> Breast Lump Removal | <input type="checkbox"/> Bunion Removal | <input type="checkbox"/> Carotid Artery Surgery | <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Cervical Spine Surgery |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Cosmetic Breast Surgery | <input type="checkbox"/> C-Section | <input type="checkbox"/> Facelift | <input type="checkbox"/> Gallbladder Removal |
| <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Heart Bypass Surgery | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hemorrhoid Surgery | <input type="checkbox"/> Hernia Repair |
| <input type="checkbox"/> Hip Joint Replacement | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Knee Arthroscopy | <input type="checkbox"/> Knee Joint Replacement |
| <input type="checkbox"/> Knee Surgery | <input type="checkbox"/> LASIK Eye Surgery | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Lumbar Spine Surgery | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Prostate Removal | <input type="checkbox"/> Rotator Cuff Surgery | <input type="checkbox"/> TMJ Surgery | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Surgical History was reviewed:
Not contributory | | | | |

Medications

Please select all medications that you are currently taking:

- | | | | | |
|---|--|-------------------------------------|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Analgesics | <input type="checkbox"/> Antacids | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Anti-Inflammatory | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Birth Control |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Bone Density | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Daily Vitamins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestion | <input type="checkbox"/> Heart | <input type="checkbox"/> Muscle Relaxers | |
| <input type="checkbox"/> OTC | <input type="checkbox"/> Pain | <input type="checkbox"/> Steroids | <input type="checkbox"/> Thyroid | |

Allergies

Please select all items that you are allergic to:

- | | | | |
|-------------------------------|-------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Chemical | <input type="checkbox"/> Environmental |
| <input type="checkbox"/> Food | <input type="checkbox"/> Medication | <input type="checkbox"/> Seasonal | |

Social History

Please answer the following questions:

- | | | | | |
|----------------------------------|--|----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Married | <input type="checkbox"/> Single | <input type="checkbox"/> Widowed | <input type="checkbox"/> Divorced | <input type="checkbox"/> Separated |
| Do you have any children? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, how many? _____ | | |
| Do you use: | <input type="checkbox"/> Tobacco | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Coffee | |