

Updated Patient Form

Name: _____ **Date of Birth:** ____/____/____ **Age:** ____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Sex: F M **Height:** _____ **Weight :** _____ **Race:** _____ **Ethnicity:** _____ **Primary Language:** _____

Patient's Marital Status _____ **Nearest Relative** _____ **Spouse's Name** _____

Patient's Address _____ **City** _____ **Zip** _____

Name of Responsible Party if Patient is a Minor _____

Insurance _____ **Main subscriber on the insurance** _____ **DOB** _____

Home Phone () _____ **Cell** () _____ **Email** _____

Patient's Employer (If minor, ResponsibleParty) _____ **Occupation** _____

Work Address _____ **Work Tel** () _____

Spouse's Employer _____ **Spouse's Name** _____ **Work Tel** () _____

Name of person making referral: _____

Primary Care Physician/Internist: _____ **Cardiologist:** _____

Would you like records sent to any of these Doctors? (Yes/No) Please Circle One

Have you had a recent medical evaluation by one of these doctors? _____ **Name of Doctor:** _____

What is your primary problem for being seen today?

Where is your Pain? Body Part: _____ **Right or Left (circle one)**

Length of Symptoms: _____ **Date of Injury:** _____

Describe your injury and symptoms: _____

Does your pain **Radiate** up or down? YES NO (If yes: up down both)

Do you have any weakness? YES NO

Do you have **Numbness and/or tingling**? YES NO

Have you had **Surgery** on this body part? YES NO

If yes, describe the procedure: _____

Date(s) / Surgeon(s): _____

Have you had **Physical Therapy**? YES NO If yes, how many visits _____

Have you had any **Images** taken on this MRI CT EMG Bone Scan Xray (circle all that apply)

body part? **Findings:** _____

Have you had an **Injection**(s)? YES NO If yes, how many _____

What **Pain Medicine** are you taking for this problem? _____

Past Medical History:

In the past 4 weeks, have you had a cough, cold, sore throat or bronchitis that required treatment? _____

List any medical conditions you have: (ex High blood pressure, mitral valve prolapsed)

Drug Allergies: Yes No **List allergies?** _____

Type of Reaction: _____

Name: _____

LAST

FIRST

MIDDLE INITIAL

MAIDEN

Current Medications (List any medications you are taking. Include such items as aspirin, vitamins, calcium, **DIET PILLS** ETC)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication?	Please Check: Helped?		
			A Lot All	Some	Not at
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you used blood thinners, such as Coumadin, Heparin, Aspirin, Ibuprofen, or Plavix, with in the past 2 weeks? **Yes/No**

If yes, please list _____

Have you ever taken steroids, such as Prednisone or Medrol, by mouth? ___ If yes, when and for how long? _____

Do you take medication for Osteoporosis such as Fosamax, Actonel, or Boniva? _____

Date of last EKG ____/____/____ Date of last Blood draw ____/____/____ Date of last Chest X-ray ____/____/____

List All Surgeries

Date

Reason

	Date	Reason
1.		
2.		
3.		
4.		
5.		
6.		

Have you ever smoked? Yes No Quantity/Amount: _____ If quit, how long ago? _____

Do you drink alcohol? Yes No number per week _____ Has anyone ever told you to cut down on your drinking? Yes No

Do you use recreational drugs, such as marijuana, cocaine, meth? Yes No If yes, please list _____

Pharmacy Information:

Pharmacy Name: _____ **City:** _____

Pharmacy address or cross streets (if known): _____

Telephone number (if known): _____