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PATIENT HISTORY & PHYSICAL FORM

BP:_____ **PULSE:**_____ **DATE:**_____

AGE:_____ **HEIGHT:**_____ **WEIGHT:**_____

Patient Name:_____

Doctor Requesting Consult (Name/Address):_____
_____

Is there anyone you would like to send a report of your visit to?

Name/Address:_____

Name/Address:_____

HISTORY OF PRESENT ILLNESS:
Chief Complaint List of detailed symptoms, location and description of pain.
(Example: I am having pain in my lower back with radiation down my legs.)

_____
_____
_____

When did present episode of pain begin?_____
Where and how did this episode start?_____
Have you ever had anything like this before? If yes, when? How?_____
_____

Neck/Upper Back:

Have you ever experienced arm and hand numbness/weakness? _____ Yes _____ No
Based on a total of 100%, what percentage of your pain is in your _____% Neck _____% Arms

Mid/Lower Back:

Have you experience leg numbness/weakness? _____ Yes _____ No
Based on a total of 100%, what percentage of your pain is in your _____% Back _____% Legs

1. What makes the pain worse? (Circle any that Apply)
    a. Sitting
    b. Standing
    c. Walking
    d. Bending Forward
    e. Bending Backward
    f. Coughing

2. What reduces the pain? (Circle any that Apply)
    a. Sitting
    b. Standing
    c. Walking
    d. Medications
    e. Exercise
    f. Lying Down

PAST MEDICAL TREATMENT:

Have you been treated by another doctor for this injury or complaint? _____ Yes _____ No
If Yes, please list the doctor(s) name(s) and location(s):

1. _____
   _____

2. _____
   _____

Have you had any diagnostic test performed for this problem? (Please check any that apply)

TEST	DATE	TEST	DATE
X-Rays		Bone Scan	
MRI		Discogram	
Myelogram		CAT Scan	
Dexascan		Other	

What other treatments have you tried for your problem/complaint? (Please check any that apply)

TREATMENT	DATE	TREATMENT	DATE
Physical Therapy		Chiropractor	
Acupuncture		Surgery	
Epidural Steroids		Pain Management	
Other			

PAST HEALTH HISTORY: (please check any that apply)

	√		√
Asthma		Kidney Disease	
Angina (Heart Pain)		Arthritis	
Diabetes		Stroke	
Cancer		Hepatitis	
Tuberculosis		Liver Disease	
Heart Disease		Thyroid	
High Blood Pressure		Stomach Ulcers	
Lung Disease		Blood Clots	
Anemia		Seizures	
Other		Do you smoke? (check if yes)	

SURGERIES, HOSPITALIZATION, SERIOUS INJURIES:

Have you have had a **SPINAL SURGERY?** If yes, please list dates, procedure, and surgeon.

_____
_____
_____

Please list other SURGERIES that you have had. Please include date, procedure, and surgeon.

_____
_____
_____

MEDICATIONS: (Please list all current medications you are taking. Prescriptions, over the counter, and herbal medications included.)

_____
_____

ALLERGIES: Are you allergic to any medication? _____ YES _____ NO (If yes, please list below)

_____

Do you have an allergy to Latex? _____ YES _____ NO

Do you have an allergy to shellfish, iodine or x-ray contrast? _____ YES _____ NO

FAMILY HISTORY: (Please check any that apply to your family)

PROBLEM	YES	NO	SCPECIFY RELATIONSHIP AND DATES
ARTHRITIS			
CANCER			
HEART DISEASE			
OSTEOARTHRITIS			
BACK PROBLEMS			
DIABETES/THYROID			
HIGH BLOOD PRESSURE			
NEUROLOGIC DISEASE			
SCOLIOSIS			

WORK HISTORY:

Occupation: _____

Employer Name/Address:_____

_____

Are you Currently Working? _____ YES _____ NO

□ Full Time □ Part Time □Unable to Work

□ Unemployed □ Retired □ On Disability

How many days have you missed in the past year due to your spine problem? _____

SOCIAL HISTORY:

- Education: (Grade School - Middle School - High School - College - Graduate School)
- Marital Status (Single - Married - Widow - Divorced)
- Number of Children: _____
- Do you Smoke? ___ YES ___ NO If yes → ____ pack(s) a day. Number of years? _____
- Did you previously smoke? ___ YES ___ NO If yes → ____ pack(s) a day. Number of years? _____
- Do you drink alcoholic beverages? _____ YES _____ NO How much?_____
- Do you now, or have you ever taken illicit intravenous drugs? ____ YES ____ NO

REVIEW OF SYMPTOMS: (Please check all symptoms you have experienced in the past 2 months)

- General: ____ fever/chills ____ weight loss ___ other:_____
- Eyes: ____ vision loss ____ glasses/contacts ___ other:_____
- ENT: ____ hearing loss ____ dentures ___ other:_____
- Cardiac: ____ chest pain ____ palpitations ____ other: _____
- Respiratory: ____ shortness of breath ____ cough
  ____ wheezing ____ other: _____
- GI: ____ bowel dysfunction (incontinence) ____ nausea/vomiting
  ____ rectal bleeding ____ other:_____
- GU: ____ bladder dysfunction (incontinence) ____ frequency
  ____ painful voiding ____ other: _____
- Musculoskeletal: ____ joint pain ____ joint swelling
  ____ morning stiffness ____ other: _____
- Skin: ____ rashes ____ lesions
  ____ itching ____ other: _____
- Neuro: ____ balance difficulties ____ seizure
  ____ headache ____ other: _____
- Psych: ____ depression ____ anxiety
  ____ mania ____ other: _____

- Hematologic/Lymphatic: ____ bleeding tendency ____ bruising
  ____ swollen glands ____ other: _____
- Allergies/Immunologic: ____ decreased immunity ____ frequent infections
  ____ other: _____

****My signature signifies that I have read, answered and understand the above information to be true and accurate.****

Patient/Guardian Signature:_____

Physician Use Only: (Comments/Notes):

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