

PATIENT HISTORY

Date of Birth _____ Social Security Number _____ - _____ - _____
Last Name _____ First Name _____
Address _____ Apt # _____
City _____ ST _____ Zip _____
Phone (Cell) _____ (H) _____ (Work) _____
Spouse's Name _____
Your Occupation _____ Employer _____
Employer Address _____ Insurance Company _____
Insurance ID # _____ Policy or Group Number _____
Have you ever been to another doctor for this problem? Y N Who? _____
How did you hear about our office? _____ E-Mail _____

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive (over time)
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____ Ache _____ Burn _____ Throb
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____ Y _____ N
- How often do you experience these symptoms?
_____ 100% _____ 75% _____ 50% _____ 25% _____ 10%
- PAIN INTENSITY: Please put a vertical line or X on the scale for the intensity of your pain.

No Pain _____ Unbearable Pain

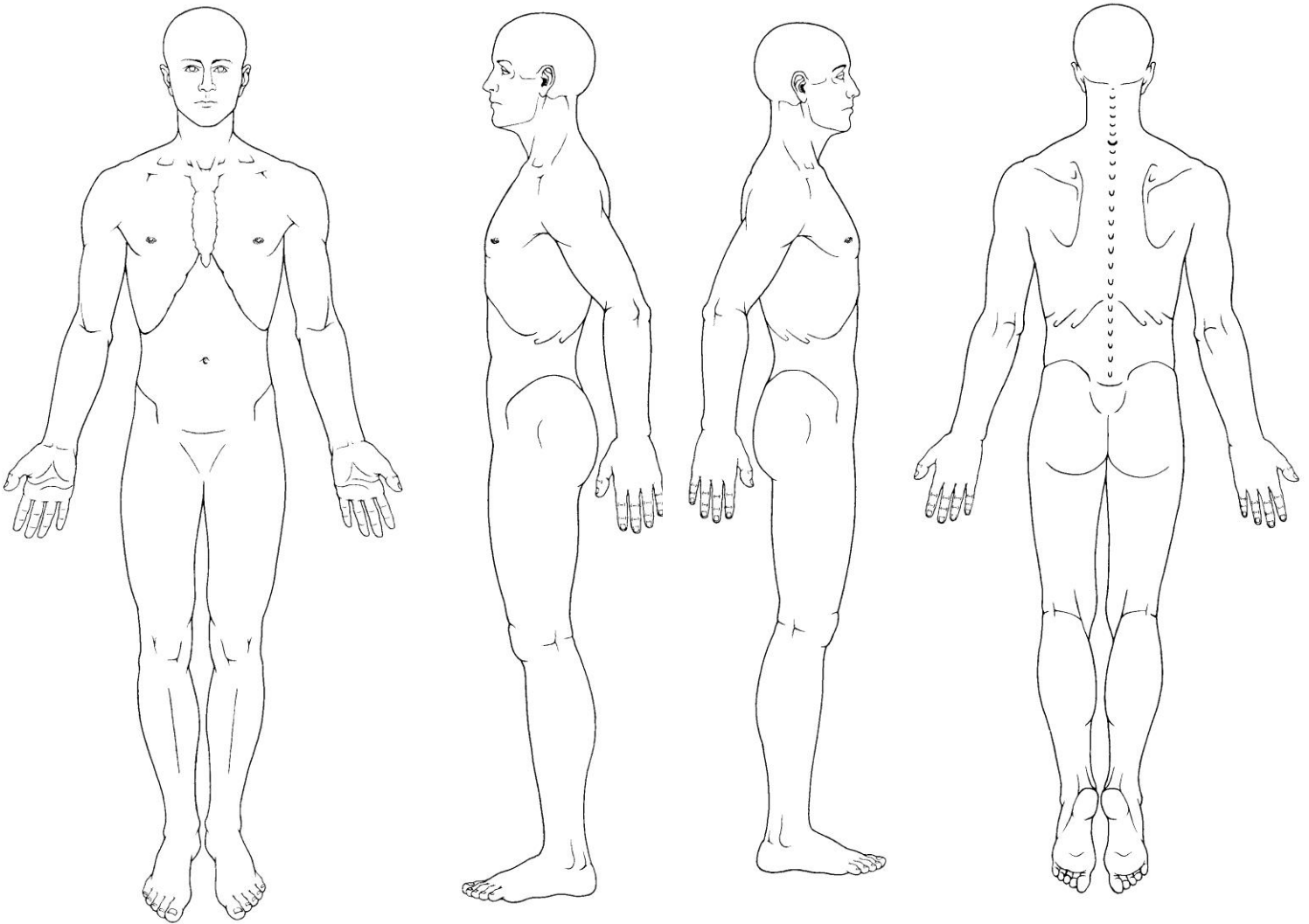
OTHER COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____ Ache _____ Burn _____ Throb
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____ Y _____ N
- How often do you experience these symptoms?
_____ 100% _____ 75% _____ 50% _____ 25% _____ 10%
- PAIN INTENSITY: Below put a vertical line or X on the scale for the intensity of your pain.

No Pain _____ Unbearable Pain

PATIENT SIGNATURE _____ DATE _____

PAIN LOCATION



**Please mark off the areas of your complaint on the diagram above.
Please use the following symbols on the pain diagram to accurately
describe your condition.**

- PPP** **Where you experience Pain**
- NNN** **Where you experience Numbness**
- TTT** **Where you experience Tingling**
- BBB** **Where you experience Burning**
- CCC** **Where you experience Cramping**

PATIENT SIGNATURE _____ DATE _____

PATIENT HISTORY

Please list all previous treatments for this condition:

Name of Treating Physician _____ Dates of Treatment _____

Type of Treatment or Drugs Prescribed _____

Name of Treating Physician _____ Dates of Treatment _____

Type of Treatment or Drugs Prescribed _____

Please list all past surgeries:

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Please list all previous accidents and falls:

What _____ When _____

What _____ When _____

What _____ When _____

What _____ When _____

Please list any medications or vitamins you are currently taking:

Please do not write below this line.

DOCTORS NOTES:

PATIENT SIGNATURE _____ DATE _____