



Please use black or blue ink - Please print

Today's Date ____/____/____

Primary Care Physician	Referring Doctor Name	Physician of Record

Patient Information

Patient Name	Home Phone	Work Phone	Cell Phone
Address			Social Security No.
City		State	Zip
Date of Birth	Age	If under age 17, provide parent/guardian name(s)/phone number.	
		<input type="checkbox"/> Male	email address
		<input type="checkbox"/> Female	
Employer		Occupation	

Race Asian Black or African American White Native American Multiracial Other _____

Ethnic Group Hispanic Non-Hispanic Other _____

Preferred language English Spanish German French Other _____

Relationship Status Single Married Divorced Widowed Other _____

Name of spouse/partner/significant other (living with you)*	Daytime phone	*This person will be indicated as your primary contact in case of emergency
---	---------------	---

Please provide name and telephone number of a family member or friend (not living with you) for use in case of emergency.

Name	Relationship	Daytime Phone
------	--------------	---------------

Insurance Information

Name of Insured	Insured's Date of Birth	Policy Number
Insurance Company	Employer	Work Number

Personal Injury

Is the reason for your office visit an illness/injury resulting from an automobile accident? Yes No

Workers' Compensation Information

Diagnoses recognized on claim _____

State _____ Date of Injury _____ Claim # _____

Managed Care (MCO) Provider _____ MCO Phone _____

Employer at time of injury _____ Claim Allowed Claim Litigated

Patient Name _____

Vital Signs / History of Illness

<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Right handed	<input type="text"/>	<input type="text"/>
Height	Weight	<input type="checkbox"/> Left handed	Blood Pressure	Pulse

What are your current symptoms? _____

What did your physician tell you about your spine problem? _____

Where is your pain located?

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> neck | <input type="checkbox"/> left hip | <input type="checkbox"/> middle back | <input type="checkbox"/> left shin/calf | <input type="checkbox"/> right shin/calf |
| <input type="checkbox"/> upper back | <input type="checkbox"/> right shoulder | <input type="checkbox"/> lower back | <input type="checkbox"/> left foot | <input type="checkbox"/> right foot |
| <input type="checkbox"/> left shoulder | <input type="checkbox"/> right upper arm | <input type="checkbox"/> right buttock | <input type="checkbox"/> left toes | <input type="checkbox"/> right toes |
| <input type="checkbox"/> left upper arm | <input type="checkbox"/> right forearm | <input type="checkbox"/> left buttock | <input type="checkbox"/> right hip | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> left forearm | <input type="checkbox"/> right hand | <input type="checkbox"/> left upper leg | <input type="checkbox"/> right upper leg | _____ |

If more than one location is checked, where is your pain the worst? _____

Severity of pain (circle one): 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain 10 = worst pain)

The pain is constant intermittent sharp/stabbing dull/aching

Does your pain radiate to the arm? If so, to which part? Check all that apply.

- above the elbow below the elbow the hand

Does your pain radiate to the leg? If so, to which part? Check all that apply.

- the outside of the leg the inside of the leg the top of the leg the back of the leg

Do you experience numbness or tingling? If so, where? Check all that apply and circle "R" for right or "L" for left.

- arm: R / L foot: R / L leg: R / L neck upper back other _____
 fingers: R / L hand: R / L toes: R / L midback low back _____

Do you experience weakness? If so, where? Check all that apply and circle "R" for right or "L" for left.

- arm: R / L leg: R / L foot: R / L other _____

The symptoms began as a result of an injury at work a motor vehicle accident an injury outside of work

spontaneously with no known cause What was the date of the accident or injury? _____

Explain how it happened _____

These symptoms have been present for 1-7 days 8-14 days 14-21 days 1 month 2 months

3 months 6 months 9 months 12 months greater than 12 months

These symptoms started on (give specific date, if known) _____

These symptoms improve when you stand walk sit lie down change positions never improve

These symptoms worsen when you stand walk sit lie down change positions never worsen

Has there been any change in your daily activities due to these symptoms? no yes

Since what date have you been unable to perform your daily routine? _____

Are you able to work with your condition? no yes

Since the onset of symptoms, have you experienced any new problems urinating or having bowel movements? no yes

Previous Diagnostic Tests

Check any of the following diagnostic tests, or treatments you have had for this illness or injury

Plain x-rays	Mo./Yr. Where	Bone scan	Mo./Yr. Where
_____	____/____ _____	_____	____/____ _____
MRI scan	____/____ _____	Myelogram	_____
CT scan	____/____ _____	Other	____/____ _____
EMG/NCV	____/____ _____		

Previous Treatment

Have you had chiropractic treatment in the last 12 months? yes no If yes, please answer the following:

Who is the chiropractor? _____

When was your first visit? _____

How many times have you gone? _____

Did your symptoms improve? yes no

Treatment types:

- electrical stimulation
- ultrasound
- excercises
- ice
- manipulation
- physical conditioning
- massage
- hot packs
- traction
- other _____

Have you had physical therapy in the last 12 months? yes no If yes, please answer the following:

Who is the physical therapy provider? _____

When was your first visit? _____

How many times have you gone? _____

Did your symptoms improve? yes no

Treatment types:

- aquatics
- electrical stimulation
- ultrasound
- massage
- excercises
- manipulation
- ice
- physical conditioning
- hot packs
- traction
- other _____

Have you had epidural steroid injections (ESI) in the last 12 months? yes no If yes, please answer the following:

How many injections have you had? _____ When was your first one? _____

Did your symptoms improve? yes no When was your last one? _____

Medication History

List all medications you are taking now, including "over the counter" and prescription pain medications:

Name	Strength	Directions	Name	Strength	Directions
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Your Pharmacy Name _____ **Phone** _____

Are you taking any blood thinners (such as aspirin, Coumadin or Plavix)? yes no

If yes, which one? _____

Allergies

Are you allergic to any medications? yes no If yes, which medicine? _____

What happens? _____

Are you allergic to iodine contrast dye shellfish latex tape

What happens? _____

Do you have any other allergies? yes no If yes, what are you allergic to? _____

What happens? _____

Have you ever had an allergic reaction to a blood transfusion? yes no

Past Surgical/Medical History

Have you ever had any neck or back operations/surgery? yes no

If yes, when? _____ Surgeon's name _____

Describe area of spine operated _____

Have you ever had a surgery on your neck or chest? yes no

If yes, describe the surgery _____

Have you ever had a cardiac/heart procedure (e.g. angioplasty, stents) yes no

If yes, what procedure was performed? _____ Date: _____

Have you ever had any other operations/surgery? yes no

If yes, when? _____ Describe the surgery _____

Have you been diagnosed with any of the following? (check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes | <input type="checkbox"/> lung disease/COPD/emphysema | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> angina/chest pain | <input type="checkbox"/> elevated cholesterol | <input type="checkbox"/> malignancy/cancer | <input type="checkbox"/> staph infection (e.g. MRSA) |
| <input type="checkbox"/> arrhythmia/irregular heartbeat | <input type="checkbox"/> heart attack | <input type="checkbox"/> mental health disorder/depression/anxiety | <input type="checkbox"/> stroke |
| <input type="checkbox"/> asthma | <input type="checkbox"/> heart disease | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> thyroid disease |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> peripheral vascular disease | |
| <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> kidney disease | <input type="checkbox"/> phlebitis/bleeding disorder | |

Do you have any other medical conditions? yes no

If yes, explain _____

Do you have any other implant devices (ie, pacemaker, morphine pump, spinal cord stimulator) yes no

Explain _____

Have you ever been treated for blood clots or excessive bleeding? yes no

Is there any reason you cannot receive blood or blood products? yes no

If yes, explain _____

Social History

Do you live alone? yes no
Indicate your marital status single married widowed divorced partner
If married, does your spouse work? yes no
Are you pregnant? yes no **If yes, when is your due date?** _____
Do you have any children? yes no
If yes, indicate sex, age(s) and whether they live at home _____

Do you now use tobacco products? yes no
If yes, specify cigarettes chewing tobacco snuff tobacco cigars pipe
How much/day _____ For how many years _____
If in the past but you quit, when did you quit _____

Do you now drink alcohol? yes no recovering alcoholic
If yes, specify beer wine liquor
How many drinks/week _____ For how many years _____
If in the past but you quit, when did you quit _____

Do you now use any recreational drugs? yes no
If yes, specify marijuana cocaine speed hallucinogens narcotics other
How much/day _____ For how many years _____
If in the past but you quit, when did you quit _____

Have you ever received treatment for drug and/or alcohol problems? yes no
If yes, specify when and where _____

Work History

Highest grade level achieved in school grade school high school college post college
Are you currently employed? yes no retired

Employer _____

Length of employment _____

Job title _____

How long have you done this job? _____

If employed, are you currently working with these symptoms? yes no

If not currently working, did a physician place you off work? yes no

If yes, please list physician's name _____

If not currently working, when did you stop working? _____

Does your job require you to:

- lift ___ pounds
- sit
- use a computer
- lift over head
- bend
- drive a truck or forklift
- reach over head
- stand

Family History

Has anyone *in your family* had any of the following conditions?

Alzheimer's/memory loss	<input type="checkbox"/> yes <input type="checkbox"/> no	high blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	stroke/brain tumor/aneurysm	<input type="checkbox"/> yes <input type="checkbox"/> no
cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	kidney disease	<input type="checkbox"/> yes <input type="checkbox"/> no	other problems	_____
depression/mental problems	<input type="checkbox"/> yes <input type="checkbox"/> no	lung problems	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	multiple sclerosis	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
heart problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Parkinson's	<input type="checkbox"/> yes <input type="checkbox"/> no		

Do you currently have any of the following problems (please answer "Yes" or "No" to every item; do not skip any):

GENERAL

- fever yes no
- chills yes no
- sweats yes no
- anorexia yes no
- fatigue yes no
- malaise (body weakness) yes no
- weight loss yes no

EYES

- blurring yes no
- diplopia (double vision) yes no
- eye irritation yes no
- eye discharge yes no
- vision loss yes no
- eye pain yes no
- photophobia (sensitivity to light) yes no

EAR/NOSE/THROAT

- earache yes no
- ear discharge yes no
- tinnitus (ringing in ears) yes no
- decreased hearing yes no
- nasal congestion yes no
- nosebleeds yes no
- sore throat yes no
- hoarseness yes no
- dysphagia (difficulty swallowing) yes no

HEART

- chest pains yes no
- palpitations yes no
- syncope (passing out) yes no
- difficulty breathing on exertion yes no
- difficulty breathing when sitting/standing yes no
- peripheral edema yes no

RESPIRATORY

- cough yes no
- difficulty breathing yes no
- excessive sputum yes no
- hemoptysis (spitting up blood) yes no
- wheezing yes no

GASTROINTESTINAL

- nausea yes no
- vomiting yes no
- diarrhea yes no
- constipation yes no
- change in bowel habits yes no
- abdominal pain yes no
- melena (black or tarry stool) yes no
- bloody stool yes no
- jaundice yes no

PSYCHIATRIC

- depression yes no
- anxiety yes no
- memory loss yes no
- hallucinations yes no
- other mental health problems yes no

GENITOURINARY

- vaginal discharge yes no
- incontinence yes no
- difficulty urinating yes no
- urinating blood yes no
- urinary frequency yes no
- amenorrhea (no menstrual cycle) yes no
- menorrhagia (excessive menstrual flow) yes no
- abnormal vaginal bleeding yes no
- pelvic pain yes no

MUSCULOSKELETAL

- back pain yes no
- neck pain yes no
- joint pain yes no
- joint swelling yes no
- muscle cramps yes no
- muscle weakness yes no
- stiffness yes no
- arthritis yes no

SKIN

- rash yes no
- itching yes no
- dryness yes no
- suspicious lesions yes no

NEUROLOGIC

- intermittent paralysis yes no
- weakness yes no
- paresthesia (prickly/tingling sensation) yes no
- seizures yes no
- syncope (passing out) yes no
- tremors yes no
- vertigo (dizziness) yes no
- numbness yes no
- imbalance yes no
- incoordination yes no
- headache yes no
- visual changes yes no
- tinnitus (ringing in ears) yes no

ENDOCRINE

- cold intolerance yes no
- heat intolerance yes no
- polydipsia (excessive thirst) yes no
- polyphagia (excessive eating) yes no
- polyuria (excessive urination) yes no
- weight change yes no

HEME/LYMPHATIC

- abnormal bruising yes no
- abnormal bleeding yes no
- enlarged lymph nodes yes no

ALLERGY

- urticaria (itching) yes no
- hay fever yes no
- persistent infections yes no
- HIV exposure yes no

IMMUNOLOGIC

- persistent infections yes no
- HIV exposure yes no

Patient signature _____ Date _____

Mayfield physician signature _____ Date _____