New Patient Paperwork

Patient Account #________
Doctor # ______________
Reviewed By ___________

Patient Contact & Background Information

Name____**Age**______**DOB**__________
Last First M.I.

Address____

Home #__________________**Cell #**_____________________**Work #**__________________

SSN:_________________ **Email** _____________________________

Emergency Contact Name_________________________ **Phone #**____________________

Relationship to Patient ____________________________

Employer____________________________ **Address/Phone**_________________________

Referring Doctor _______________________**Address**_____________________________

PCP_________________________________**Address**_______________________________

Is this a second opinion for treatment? Yes No

Insurance Company Name _________________________ **Member ID #** ____________

Group # ______________ **Name of Insured** ___________________ **DOB** __________

What is the main problem (s) for which you are seeking treatment?

____

____

____

____

Height:_____'____". **Weight**______**lbs** ☐ Male ☐ Female ☐ Rt. Handed ☐ Lt. Handed

Printed Name: ____

Signature: ____Date ___________

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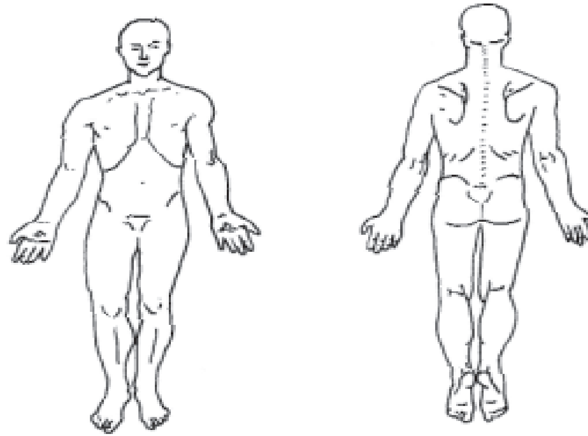
Patient Pain Assessment

Using the appropriate symbols, mark on the body diagram where you feel the following sensations:

Numbness	Pins & Needles	Burning	Stabbing (Sharp) Pain	Aching
=====	ooooo	XXXXX	/////	*****



Please circle on the line below how bad your pain is NOW.

Back Pain	0 --—1--------2--------3--------4--------5--------6--------7-------8-------9 ------------- 10 Worst
Leg Pain	0 --—1--------2--------3--------4--------5--------6--------7-------8-------9 ------------- 10 Worst
Neck Pain	0 --—1--------2--------3--------4--------5--------6--------7-------8-------9 ------------- 10 Worst
Arm Pain	0 --—1--------2--------3--------4--------5--------6--------7-------8-------9 ------------- 10 Worst

Patient Background & Medical History

Section 1: Review of Symptoms (Please check all items that apply or circle NONE)

- ☐ Unexplained Weight Loss/Gain
- ☐ Bladder Accidents/Incontinence
- ☐ Bowel Accidents/Incontinence
- ☐ Night Sweats
- ☐ Fevers
- ☐ Genital Numbness
- ☐ Severe Nighttime pain
- ☐ Recent Infections
- ☐ Changes in appetite
- ☐ Arm Numbness
- ☐ Leg Numbness
- ☐ New Swelling (legs or arms)
- ☐ Change in Handwriting
- ☐ Difficulty Walking
- ☐ New Balance Problems
- ☐ Difficulty Buttoning
- ☐ Mood Changes
- ☐ Fatigue
- ☐ Stiffness
- ☐ Joint Pain
- ☐ Poor Sleep
- ☐ Rashes
- ☐ Bruising/Bleeding
- ☐ Visual Difficulties
- ☐ Other: (please specify) ____

Printed Name: ____

Signature: ____Date ____________

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Section 2: Past Medical History (Please check all that apply or circle NONE)

- ☐ Heart Disease
- ☐ Osteoarthritis
- ☐ Seizures/Epilepsy
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Psychiatric Illness
- ☐ Diabetes
- ☐ Ulcers
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Acid Reflux
- ☐ Rheumatoid Arthritis
- ☐ Thyroid Disease
- ☐ High Cholesterol
- ☐ Cancer: (please specify) ____
- ☐ Other: (please specify) ____

Section 3: Allergies (None)

(Please check ALL medications that apply to you and the reaction/s you have)

- ☐ Penicillin (Reaction) ____
- ☐ Sulfa (Reaction) ____
- ☐ Codeine (Reaction) ____
- ☐ Iodine (Reaction) ____
- ☐ Other ____

Section 4: Family History (*Please check any diseases diagnosed in your blood relatives*)

- ☐ Cancer
- ☐ Bleeding Disorder
- ☐ Stroke
- ☐ Diabetes
- ☐ Cardiac
- ☐ Arthritis
- ☐ Back/Neck Pain
- ☐ Other ____

Section 5: Social History (Please answer all questions)

Are you:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

Do you live:

- ☐ Alone
- ☐ With others: ____
- ☐ Retirement Home: ____

Printed Name: ____

Signature: ____Date _____________

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Highest Level of Education:

- ☐ High School
- ☐ College
- ☐ Graduate
- ☐ Other ____

Occupation:

- ☐ Retired
- ☐ Disability
- ☐ Social Security
- ☐ Employed
- ☐ Current Occupation: ____

Is your job activity:

- ☐ Sedentary
- ☐ Medium
- ☐ Light
- ☐ Heavy

Have you ever smoked?

- ☐ No
- ☐ Yes
- ☐ Quit

Packs per day/Number of years: ___________________________

Do you currently drink alcohol?

- ☐ No
- ☐ Yes
- ☐ Quit

Types of alcohol/Number of times per week: ___________________________

Do you currently use illicit drugs?

- ☐ No
- ☐ Yes
- ☐ Quit

What/How often: ___________________________

Section 6: Medications

Please list all prescription & non-prescription (over the counter) medications, dosages and frequency

____

____

Name & Address of Pharmacy: ____

Are you taking blood thinners?

- ☐ No
- ☐ Yes (check all that apply with dosage/frequency)
  - Aspirin ____________________________
  - Coumadin ___________________________
  - Plavix _____________________________
  - Other _____________________________

Printed Name: ____

Signature: ____Date ____________

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Section 7: Past Surgical History (check all that apply)

- ☐ Lumbar (lower back)
- ☐ Cervical (neck)
- ☐ Heart
- ☐ Bowel
- ☐ Stents
- ☐ Hernia
- ☐ Lung
- ☐ Gallbladder
- ☐ Kidney
- ☐ Prostate
- ☐ Thyroid
- ☐ Breast
- ☐ Arm/Leg
- ☐ Other: _________________

Name of Surgeon(s): ____

Patient Injury Details

When did your present problem begin? ____

Have you experienced similar pain in the past?

☐ No ☐ Yes If Yes, when? ____

How did your pain begin? (Check all that apply)

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ Accident on: ____
- ☐ After a fall
- ☐ Bending
- ☐ No apparent cause
- ☐ Twisting
- ☐ Pulling

What activities make your pain worse? (Check all that apply)

- ☐ Lying
- ☐ Standing
- ☐ Sitting
- ☐ Walking
- ☐ Exercise (During)
- ☐ Exercise (After)
- ☐ Bending forward
- ☐ Bending backward
- ☐ Twisting
- ☐ Coughing

What reduces your pain? (Check all that apply)

- ☐ Lying
- ☐ Standing
- ☐ Sitting
- ☐ Walking
- ☐ Exercise (During)
- ☐ Exercise (After)
- ☐ Bending forward
- ☐ Bending backward
- ☐ Twisting
- ☐ Coughing

Printed Name: ____

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What conservative treatments have you tried for this current pain? (Check all that apply and give provider's name)

- ☐ Home Exercises
- ☐ Acupuncture
- ☐ Decompression
- ☐ Chiropractic: ____
- ☐ Pain Management: ____
- ☐ Physical Therapy: ____

Who have you seen for this current pain? (Please provide dates)

- ☐ Primary MD/PA/NP _____
- ☐ Emergency Room _____
- ☐ I have not been treated
- ☐ Urgent Care ______
- ☐ Hospitalized _____

Have you had any of the following tests? (Please provide dates)

- ☐ Xray ________
- ☐ MRI ________
- ☐ CT Scan ________

Is your pain due to a work-related injury? ☐ No ☐ Yes If Yes, when? __________________

Are you still working? ☐ No ☐ Yes If No, last day on the job: __________________

Is your pain due to an auto accident? ☐ No ☐ Yes If Yes, when? _________________

Is a lawyer involved in your injury? ☐ No ☐ Yes

If Yes, please provide us with the attorney's name, phone and address:

____

____

Thank you!

Printed Name: ____

Signature: ____Date ____________