PATIENT INFORMATION PACKET
(Check All That Apply)

Reason for Visit

Primary reason for this visit is:
- ☐ Low back
- ☐ Leg pain
- ☐ Mid back pain
- ☐ Neck pain
- ☐ Arm pain

Due to injury: ☐ yes ☐ no

Previous occurrence(s):
- ☐ No previous occurrence
- ☐ 1-4 previous occurrences
- ☐ more than 4 times

Prior treatment for this recent problem?
☐ yes ☐ no

Prior surgery for this problem?
☐ yes ☐ no

Off work due to this recent problem?
☐ yes ☐ no how long ____

Signature Verification

SIGN HERE / FIRME AQUI: _____

If your visit or encounter is witnessed or if an interpreter accompanies you, it is important for the proper identification of the person(s) verifying your signature.

_____
Witness / Name

_____
Translator / Interpreter Name

_____
Address

_____
City, State, Zip

If the patient is a minor or under legal guardianship by my signature as a guardian, I authorize evaluation and medically necessary tests and treatment.

_____
Signature of Parent / Guardian

BEFORE YOU CONTINUE

We know that filling out all these forms can be annoying – but please complete them carefully. Your accurate responses will give us a better understanding of you and your problem. From this information, we can provide you with the best medical care possible.

So, please help us help you, by taking the extra time required to answer the appropriate questions accurately. Be careful to follow the directions in each section. You may be prompted to answer all questions in a section or to move on to the next section. Clearly mark in appropriate space, circle appropriate items or write legibly where indicated.

Thank you for your cooperation.

FACTORS OF COMPLAINT

1. Explain how your pain or problem began:
☐ Recent injury ☐ On-the-job ☐ Car Accident ☐ Slip and Fall
Explain how it happened:

_____

_____

☐ I don't know how it began ☐ It is recurrent -- It comes and goes
☐ I've had it a long time ☐ Old injury (when?): _____
Describe:

_____

_____

Mark on a Scale of 1 to 10:

2. How bad is your low back pain today?
No pain (0) _____ Worst possible (10)

3. How bad is your leg/foot pain today?
No pain (0) _____ Worst possible (10)

4. How bad is your middle back pain today?
No pain (0) _____ Worst possible (10)

5. How bad is your neck or upper back pain today?
No pain (0) _____ Worst possible (10)

6 How bad is your arm/hand pain today?
No pain (0) _____ Worst possible (10)

7. I also have the following problems: (check all that apply)
☐ Weakness of muscles in arms or hands
☐ Weakness of muscles in legs, ankles or feet
☐ Numbness (loss of feeling) in: ___ arms/hands ___ legs/feet
☐ Tingling (falling asleep) in: ___ arms/hands ___ legs/feet
☐ My legs/feet fatigue when I walk too far. ☐ This is relieved by resting my legs

I can walk:
☐ less than a block ☐ 1-3 blocks ☐ more than 3 blocks

8. My pain is worse: (check all that apply)
☐ in the morning
☐ in the late afternoon
☐ at night when sleeping
☐ with coughing/sneezing
☐ when I sit
☐ when I lie down
☐ when I stand
☐ when I walk

9. Trouble with my bladder (urine) control:
☐ Can't empty bladder
☐ Loss of urine (accidents)
☐ I have a history of bladder problems
☐ I have a history of prostate problems

10. Trouble with bowels:
☐ Constipation

11. Trouble with sexual relations:
☐ Impotence
☐ Loss of erections
☐ Pain with intercourse

GENERAL MEDICAL HISTORY AND SYSTEM REVIEW (Part A)

HEIGHT: _____ **WEIGHT:** _____

I write with my RIGHT / LEFT hand.

My last general physical exam was: _____

My last hospitalization was: _____

PLACE A CHECK NEXT TO ANY DISEASE THAT APPLIES TO YOU:

1. None: ☐

2. Heart:
- ☐ angina /chest pain
- ☐ heart attack
- ☐ heart murmer
- ☐ valve disease
- ☐ pacemaker
- ☐ other: _____

3. Vascular:
- ☐ high blood pressure
- ☐ stroke
- ☐ varicose veins
- ☐ other: _____

4. Ulcers/Digestive System:
- ☐ stomach
- ☐ duodenal
- ☐ colon

5. Diabetes (high blood sugar):
- ☐ insulin dependent
- ☐ non-insulin dependent (on pills)

6. Liver Disease:
- ☐ hepatitis
- ☐ gallbladder

7. Kidney Disease:
- ☐ stones
- ☐ infections
- ☐ kidney failure / dialysis
- ☐ other: _____

8. Lung Disease:
- ☐ shortness of breath
- ☐ emphysema
- ☐ TB
- ☐ bronchitis
- ☐ pneumonia
- ☐ asthma
- ☐ other: _____

9. Blood Disorders:
- ☐ anemia
- ☐ leukemia
- ☐ bleeding tendencies
- ☐ other: _____

10. Eye Disease:
- ☐ glaucoma
- ☐ cataracts
- ☐ other: _____

11. Ear Disease:
- ☐ hearing loss
- ☐ dizziness

12. Endocrine System:
- ☐ thyroid
- ☐ pituitary
- ☐ other: _____

13. Skin Disease:
- ☐ psoriasis
- ☐ easy bruising
- ☐ problems healing

14. Arthritis:
- ☐ degenerative
- ☐ rheumatoid
- ☐ gout
- ☐ psoriatic

15. Cancer:
- ☐ Type: _____

16. Psychological Difficulties:
- ☐ depression
- ☐ psychosis
- ☐ anxiety
- ☐ other: _____

17. Ladies:
- ☐ currently pregnant (# of weeks? _____)
- ☐ menstrual problems
- ☐ vaginal bleeding
- ☐ vaginal discharge
- ☐ other: _____

18. Men:
- ☐ discharge
- ☐ problems with sexual function
- ☐ other: _____

19. Childhood Disease:
- ☐ rheumatic fever
- ☐ epilepsy
- ☐ other: _____

GENERAL MEDICAL HISTORY AND SYSTEM REVIEW (Part B)

Allergies: ☐ None
To Medicines:

_____
_____

Current Medications:

_____
_____

Major Surgeries (If yes, When):

☐ None
☐ Tonsillectomy: _____
☐ Appendectomy: _____
☐ Gall Bladder: _____
☐ Heart: _____
☐ Digestive: _____
☐ Other: _____
☐ Hysterectomy: _____
☐ Vasectomy: _____
☐ Biopsy: _____
☐ Fracture Repair: _____
☐ Joint Repair: _____
☐ Hernia: _____

Spinal Surgeries	Surgeon	Date of Surgery	No Help	Some Relief	Good Relief
Discectomy					
Microsurgery					
Laminectomy					
Fusion					
Spinal Instumentation					
Scoliosis					
Revision Surgery					

Major Injuries:
None: _____

Auto or cycle accident, etc. _____

Prior sports or misc, injuries: _____

Doctors Who Would Like To Receive Reports: _____

_____
_____
_____

TESTS AND TREATMENTS:

Any previous tests (examinations) or treatment for your current condition?
☐ No ☐ Yes

Previous tests for this condition:

TYPE	WHEN	FACILITY	RESULTS
Regular x-rays			
CAT Scan			
MRI Scan			
Myelograms			
Discography			
Nerve Tests			

Treatment for this condition:

Medications	Name(s)	No Help	Some Relief	Good Relief
Anti-Inflammatories				
Muscle Relaxants				
Pain Medications				
☐	Neurontin			
☐	Valium			

Therapies	No Help	Some Relief	Good Relief
Physical Therapy			
Chiropractic Care			
Epidural/Spine Block			
Accupuncture			

Previous Treating Doctors:

Doctor's Name	Specialty	Location	Date of Treatment

FAMILY/SOCIAL AND LIFESTYLE

Family Medical History:

Mother: ☐ Alive – Age ____ ☐ Good Health ☐ Suffers with: _____
☐ Deceased – Cause: _____

Father: ☐ Alive – Age ____ ☐ Good Health ☐ Suffers with: _____
☐ Deceased – Cause: _____

I have ☐ Living ( ) brothers/( )sisters
☐ Deceased ( ) brothers/( ) sisters, cause(s): _____

Members of my family suffer the following: (check all that apply)

☐ None
☐ High blood pressure
☐ Stroke
☐ Heart trouble
☐ Diabetes
☐ Back Problems
☐ Lung Disease
☐ Arthritis
☐ Cancer
☐ Other: _____

Social History: (check all that apply)

☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower ☐ Single

Number of children: _____ at home _____ away [other dependents: _____]

☐ I work as a _____ Previous occupation(s) _____
☐ I am retired _____ years from _____

Highest educational level attained:
☐ Grammar ☐ High School ☐ College ☐ Post Graduate

☐ I live with my children or other relatives
☐ I live by myself.
☐ I have special needs. Explain: _____

I drink:
☐ None
☐ Beer
☐ Wine
☐ "Hard Drinks"
Frequency: ☐ rarely ☐ socially ☐ daily

My use of tobacco:
☐ None
☐ I quit!! when: _____
☐ cigarettes ☐ cigar/pipe ☐ smokeless/leaf
Frequency: _____ per day for _____ years

Recreational Drugs:
☐ None ☐ Name, if any: _____

Patient's Initials _____ **Date:** __ / __ / __