



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		City	State Zip
		Social Security No.	
Date of Birth	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	
		email address	
Employer		Occupation	

Marital Status

Single
 Married
 Divorced
 Widowed
 Other

If married, name of spouse	Daytime phone for spouse

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

Name	Relationship	Daytime Phone

Insurance Information

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

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): 1 2 3 4 5 6 7 8 9 10 (1 = least 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 physical conditioning

ultrasound massage

excercises hot packs

ice traction

manipulation 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 ice

electrical stimulation physical conditioning

ultrasound hot packs

massage traction

excercises other _____

manipulation

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
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

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 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)

- anemia diabetes lung disease/COPD/emphysema sleep apnea
- angina/chest pain elevated cholesterol malignancy/cancer stroke
- arrhythmia/irregular heartbeat heart attack mental health disorder/depression/anxiety thyroid disease
- asthma heart disease osteoporosis
- congestive heart failure high blood pressure peripheral vascular disease
- coronary artery disease kidney disease phlebitis/bleeding disorder

Do you have any other medical conditions? yes no

If yes, explain _____

Have you ever had angioplasty? yes no

Do you have any stents placed? yes no **If yes, when?** _____

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

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 or have you ever used any tobacco products? in the past, but quit yes no
 If yes, specify cigarettes chewing tobacco snuff tobacco cigars pipe
 How much/day _____ For how many years _____ 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 _____

Have you ever used any recreational drugs? in the past, but quit yes no
 If yes, specify marijuana cocaine speed hallucinogens narcotics other
 How much/day _____ 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

Do you work outside the home? yes no

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

If no, when did you stop working? _____

Did a physician place you off work? yes no

If yes, who? _____

Employer _____ Length of employment _____

Job Title _____ How long have you done this job? _____

Does your job require you to:

lift ___ pounds bend
 sit drive a truck or forklift
 use a computer reach over head
 lift 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 or have had 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
- mental disturbance yes no
- suicidal thoughts yes no
- hallucinations 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

Patient signature _____ Date _____

Mayfield physician signature _____ Date _____