



**Patient Medical Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Type of activities at work? (laptop, heavy lifting, standing) \_\_\_\_\_

How did you hear about us? (doctor referral? online search?) \_\_\_\_\_

**Present Injury**

Where is the location of your pain / injury? \_\_\_\_\_

Approximate date of injury or, initiation of symptoms? \_\_\_\_\_

Briefly describe the mechanism of injury: \_\_\_\_\_

Please rate your pain on a scale of 1 (min) to 10 (emergency pain): \_\_\_\_\_ / 10    Worse in:  AM  PM

Symptom frequency:  Constant  Intermittent

Symptom Type:  Pain  Numbness  Tingling  Burning  Sharp  Other \_\_\_\_\_

What activities or positions ↑ your pain/symptoms: \_\_\_\_\_

What activities or positions ↓ your symptoms: \_\_\_\_\_

What activities are you limited/can not do due to pain? \_\_\_\_\_

Significant sporting/recreation activities/hobbies: \_\_\_\_\_

Have you received prior treatment for this injury?  Yes  No    Type? \_\_\_\_\_

Which doctors (name & type) have you seen pertaining to this injury? \_\_\_\_\_

**Medical History**

Which of the following diagnostic tests have you received for this injury?

- MRI    X-Rays    CT Scan    Bone Density    NCV    Myelogram    Other    None

List any medications you are presently taking? \_\_\_\_\_

List any medications to which you are allergic: \_\_\_\_\_

List prior surgeries or other conditions for which you have been hospitalized in the past 5 years including the approximate date and reason for surgery or hospital stay:

Date: \_\_\_\_\_ Reason: \_\_\_\_\_    Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Date: \_\_\_\_\_ Reason: \_\_\_\_\_    Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Do you have any of the following medical conditions?

Cancer    Diabetes    High Blood Pressure    Pace Maker    Osteoporosis    Seizures

HIV    Hepatitis    Asthma    Thyroid    Head Injury    Lung Disorder

Other (please explain): \_\_\_\_\_