

Account #: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Who is your Family/Primary Care Physician? \_\_\_\_\_

### CHIEF COMPLAINT

Why are you seeing the doctor today? \_\_\_\_\_

Current problem is a result of a(n): *Check all that apply*

- Car Accident       Work Accident       Accident       Other

Date this began bothering you: \_\_\_\_\_

How did accident happen? \_\_\_\_\_

Where did accident happen? \_\_\_\_\_

What makes it feel worse? \_\_\_\_\_

What makes it feel better? \_\_\_\_\_

How far can you walk without stopping? \_\_\_\_\_

Any change in bowel or bladder function? \_\_\_\_\_

Have you seen any other doctor for this problem? \_\_\_\_\_ If yes, who? \_\_\_\_\_

Have you had any prior surgery for this problem? (surgeon's name and dates) \_\_\_\_\_

Have you had any prior treatment for this problem? \_\_\_\_\_ If yes, please mark appropriate treatments:

\_\_\_\_\_ Physical Therapy – Where \_\_\_\_\_ When \_\_\_\_\_

\_\_\_\_\_ X-rays – Where \_\_\_\_\_ When \_\_\_\_\_

\_\_\_\_\_ MRI – Where \_\_\_\_\_ When \_\_\_\_\_

\_\_\_\_\_ CAT Scan – Where \_\_\_\_\_ When \_\_\_\_\_

\_\_\_\_\_ Injections – Where \_\_\_\_\_ When \_\_\_\_\_

\_\_\_\_\_ Nerve Tests – Where \_\_\_\_\_ When \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_ - Where \_\_\_\_\_ When \_\_\_\_\_

**List all current medicines and dosage:** \_\_\_\_\_

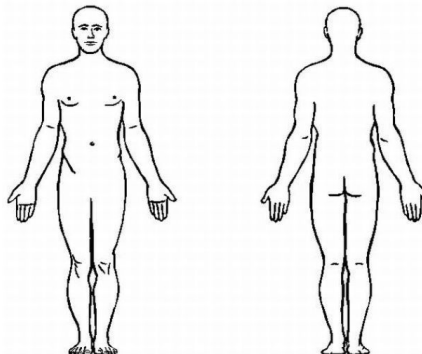
Do you have any ALLERGIES to any medications?  No  Yes List: \_\_\_\_\_

Are you allergic to latex?  No  Yes

How would you rate your pain today on a scale of 0 – 10 (circle on scale)      0 \_\_\_\_\_ 10  
No Pain 1 2 3 4 5 6 7 8 9 Most Pain

Please shade in the area where your symptoms are on the diagram below

- Symbols:  
ACHE ±  
NUMBNESS ◯  
PINS/NEEDLES ...  
STABBING ///



**PAST MEDICAL HISTORY**

**Medical History**

Please list any medical problems or accidents:

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**Surgical History**

Please list any surgeries that you have had and the date:

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Have you ever had general anesthesia?  No  Yes

Have any problems with anesthesia?  No  Yes

**SOCIAL HISTORY**

Work in the home  Employed (occupation \_\_\_\_\_)  Student  Daycare  Retired

Single  Married  Divorced  Separated  Widowed

Children?  No  Yes # \_\_\_\_\_

Do you live alone?  No  Yes

Exercise?  Daily  Weekly  Monthly  Rarely  Never

What type of exercise? \_\_\_\_\_

History of substance abuse? \_\_\_\_\_

Smoke currently?  No  Yes Packs per day \_\_\_\_\_ for \_\_\_\_\_ years

Quit smoking?  This year  less than 1 year  less than 5 years  less than 10 years

Previously smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years

Drink alcohol?  No  Daily  1 – 2 times a week  1 – 2 times a month  1 – 2 times a year

**FAMILY HISTORY**

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (mom's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Please indicate if you have experienced any of the following:

<p style="text-align: center;"><b>Constitutional</b></p> <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Unusual swelling <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches <input type="checkbox"/> History of cancer	<p style="text-align: center;"><b>Gastrointestinal</b></p> <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Constipation <input type="checkbox"/> History of ulcers <input type="checkbox"/> Chronic diarrhea <input type="checkbox"/> Blood in stools
<p style="text-align: center;"><b>Eyes</b></p> <input type="checkbox"/> Blurry vision <input type="checkbox"/> Double vision <input type="checkbox"/> Loss of vision <input type="checkbox"/> Wear glasses/contacts	<p style="text-align: center;"><b>Genitourinary</b></p> <input type="checkbox"/> Trouble with urination <input type="checkbox"/> Prostate problems <input type="checkbox"/> Incontinence <input type="checkbox"/> Trouble with erection <input type="checkbox"/> Loss of interest in sex <input type="checkbox"/> Blood in urine
<p style="text-align: center;"><b>Ears/Nose/Throat</b></p> <input type="checkbox"/> Trouble hearing <input type="checkbox"/> Use of hearing aids <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Difficulty in swallowing <input type="checkbox"/> Drooling <input type="checkbox"/> Loss of smell or taste <input type="checkbox"/> Voice change <input type="checkbox"/> Nasal drainage <input type="checkbox"/> Bloody noses	<p style="text-align: center;"><b>Musculoskeletal</b></p> <input type="checkbox"/> Joint pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis problems
<p style="text-align: center;"><b>Cardiovascular</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> History of heart attacks <input type="checkbox"/> History of heart failure <input type="checkbox"/> Palpitations <input type="checkbox"/> Irregular heart rhythm <input type="checkbox"/> High blood pressure <input type="checkbox"/> Swollen hands or feet <input type="checkbox"/> Varicose veins	<p style="text-align: center;"><b>Neurological</b></p> <input type="checkbox"/> Seizures <input type="checkbox"/> Fainting <input type="checkbox"/> Dizziness <input type="checkbox"/> Unsteadiness <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Trouble walking <input type="checkbox"/> Confusion <input type="checkbox"/> Memory Loss
<p style="text-align: center;"><b>Respiratory</b></p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Emphysema <input type="checkbox"/> Sputum production	<p style="text-align: center;"><b>Psychiatric</b></p> <input type="checkbox"/> Problems with depression <input type="checkbox"/> Medication for depression <input type="checkbox"/> Manic/depression disorder
<p style="text-align: center;"><b>Hematologic</b></p> <input type="checkbox"/> Bleeding problems <input type="checkbox"/> Bruise easily <input type="checkbox"/> Anemia	<p style="text-align: center;"><b>Endocrine</b></p> <input type="checkbox"/> Diabetics high blood sugar <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Low blood sugar
	<p style="text-align: center;"><b>Skin</b></p> <input type="checkbox"/> Rashes <input type="checkbox"/> Sores <input type="checkbox"/> Problems with psoriasis <input type="checkbox"/> Skin tumors removed

Patient Signature: \_\_\_\_\_

Date \_\_\_\_\_

**History and Physical Examination**

**Constitutional:**

Blood Pressure (sitting) \_\_\_\_\_ Temp. \_\_\_\_\_ P (R or Irreg) \_\_\_\_\_ R \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_ BMI \_\_\_\_\_

**General Appearance** (development, habits, deformities, grooming): WDWNA \_\_\_\_\_ F or M

**Skin:** Surgical Scars \_\_\_\_\_

**Spinal Alignment:**  Scoliosis  Lordosis  Kyphosis

**HEENT:** \_\_\_\_\_

**Cardiovascular:**

Peripheral

UE - Swelling: Neg/Norm \_\_\_\_\_ Pos/Abn \_\_\_\_\_

Pulses: Neg/Norm \_\_\_\_\_ Pos/Abn \_\_\_\_\_

Tender: Neg/Norm \_\_\_\_\_ Pos/Abn \_\_\_\_\_

LE - Swelling: Neg/Norm \_\_\_\_\_ Pos/Abn \_\_\_\_\_

Pulses: Neg/Norm \_\_\_\_\_ Pos/Abn \_\_\_\_\_

Tender: Neg/Norm \_\_\_\_\_ Pos/Abn \_\_\_\_\_

Varicosity: Neg/Norm \_\_\_\_\_ Pos/Abn \_\_\_\_\_

**Musculoskeletal:**

Gait and Station: Norm \_\_\_\_\_ Abn \_\_\_\_\_

Muscle tightness/spasm: Norm \_\_\_\_\_ Abn \_\_\_\_\_

Muscle Strength:

RUE: Norm \_\_\_\_\_ Abn \_\_\_\_\_

LUE: Norm \_\_\_\_\_ Abn \_\_\_\_\_

RLE: Norm \_\_\_\_\_ Abn \_\_\_\_\_

LLE: Norm \_\_\_\_\_ Abn \_\_\_\_\_

Muscle Tone (note any atrophy or abnormal movements)

RUE: Norm \_\_\_\_\_ Abn \_\_\_\_\_

LUE: Norm \_\_\_\_\_ Abn \_\_\_\_\_

RLE: Norm \_\_\_\_\_ Abn \_\_\_\_\_

LLE: Norm \_\_\_\_\_ Abn \_\_\_\_\_

Waddells: \_\_\_\_\_ of 5

**History and Physical Examination – Continued**

**Spinal ROM:** Neck Flexion \_\_\_\_\_ Extension \_\_\_\_\_ Rotation Right \_\_\_\_\_ Rotation Left \_\_\_\_\_  
Low Back Flexion \_\_\_\_\_ Extension \_\_\_\_\_ Rotation \_\_\_\_\_  
Shoulders \_\_\_\_\_  
Hips \_\_\_\_\_  
Knees \_\_\_\_\_

Neurological Sensation: Intact: \_\_\_\_\_ Abn (identify test and area) UE's \_\_\_\_\_  
LE's \_\_\_\_\_

DTR (note pathological reflexes):

Upper Extremities

BJ \_\_\_\_\_  
TJ \_\_\_\_\_  
RJ \_\_\_\_\_

Lower Extremities

KJ \_\_\_\_\_  
AJ \_\_\_\_\_

SLR/Lasegue: Sitting R \_\_\_\_\_ L \_\_\_\_\_ Supine R \_\_\_\_\_ L \_\_\_\_\_

Spurlings:  Right  Left

Tinels \_\_\_\_\_  
Phalens \_\_\_\_\_

**Radiological Tests:**

MRI \_\_\_\_\_ Visualized # of images: \_\_\_\_\_  
CT Scan \_\_\_\_\_ Visualized # of images: \_\_\_\_\_  
EMG – Report reviewed \_\_\_\_\_ Visualized # of images: \_\_\_\_\_  
Myelogram and CT \_\_\_\_\_ Visualized # of images: \_\_\_\_\_  
X-rays/other: Visualized # of images: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**History and Physical Examination – Continued**

**Impression/Diagnosis:**

1. _____	Stable	Worsening	Improved
2. _____	Stable	Worsening	Improved
3. _____	Stable	Worsening	Improved
4. _____	Stable	Worsening	Improved

**Recommendations/Counseling/Follow-Up Treatment:**

Medication: \_\_\_\_\_

Scans/X-rays: \_\_\_\_\_

Physical Therapy/Excercises: \_\_\_\_\_

Injections: \_\_\_\_\_

Surgery: \_\_\_\_\_

I verify that I have discussed with the patient or designee the risks, benefits, options and alternatives to the proposed above operation/procedure.

Other instructions/recommendations: \_\_\_\_\_

If time more than 50% counseling, total time:  15 min  30 min  40 min  60 min  80 min

Alternative benefits of procedure/treatments with patient: \_\_\_\_\_ family: \_\_\_\_\_

Discussion of findings: \_\_\_\_\_ Results: \_\_\_\_\_

Discussed with requesting physician: \_\_\_\_\_ Physician name: \_\_\_\_\_

Follow-up appointment: \_\_\_\_\_

Check here if details are included in dictated notes: \_\_\_\_\_ X-rays kept?  Yes  No

I have reviewed all data in this record and agree.

Signature: \_\_\_\_\_ Date \_\_\_\_\_