Today's Date_____

Name: _____Preferred Name:_____ Date of Birth: _____

Occupation: _____ ☐ Married ☐ Single ☐ Widowed ☐ Male ☐ Female ☐_____

Tobacco Use: **Y / N** # of years____ ☐ Former Date Quit: _____ Alcohol use? **Y / N** Dominant Hand **R / L**

Any falls in the last year? ☐ Yes ☐ No. How Many? _____ Have any falls resulted in injury? ☐ Yes ☐ No

Do you have an allergy to iodine or contrast dye? ☐ Yes ☐ No Reaction: _____

PRIMARY CARE PHYSICIAN_____ REFERRING PHYSICIAN_____

REVIEW OF SYSTEMS

☐ FATIGUE
☐ UNEXPLAINED WEIGHT LOSS
☐ FEVER
☐ EASY BLEEDING/BRUISING
☐ VISUAL CHANGES

☐ CHEST PAIN
☐ ABDOMINAL PAIN
☐ EDEMA/SWELLING
☐ HEADACHES

☐ DIZZINESS
☐ GAIT CHANGES
☐ BALANCE CHANGES

☐ EXTREMITY PAIN
☐ JOINT PAIN
☐ BACK PAIN
☐ NECK PAIN

☐ URINARY INCONTINENCE
☐ BOWEL INCONTINENCE
☐ SUDDEN CHANGE IN BOWEL/BLADDER FUNCTION

☐ EXTREMITY WEAKNESS (CIRCLE ONE) ARMS/ LEGS/ BOTH

☐ EXTREMITY NUMBNESS: INTERMITTENT/ CONSTANT/ PROGRESSIVE

YOUR MEDICAL HISTORY

☐ ALZHEIMER'S/DEMENTIA
☐ ARTHRITIS
☐ CARDIAC ARRYTHMIA/ATRIAL FIB
☐ HEART FAILURE
☐ DEPRESSION
☐ ANXIETY
☐ DIABETES
  ☐ NON-INSULIN DEPENDENT
  ☐ INSULIN DEPENDENT
☐ HIGH CHOLESTEROL
☐ GASTRIC/STOMACH ULCERS

☐ FIBROMYALGIA
☐ HEAD INJURY
☐ HEADACHES: MIGRAINE/ TENSION
☐ HEPATITIS
☐ LIVER DISEASE
☐ HYPERTENSION
☐ OSTEOPOROSIS
☐ OSTEOPENIA
☐ HIV/ AIDS
☐ CANCER TYPE/ STATUS:_____

☐ PARKINSON DISEASE
☐ NEUROPATHY
☐ POLIO
☐ RENAL DISEASE/ KIDNEY DISEASE
☐ SEIZURE DISORDER TYPE/STATUS:_____
☐ STROKE
☐ THYROID DISEASE / DISORDER
☐ TREMOR
☐ OTHER _____

YOUR SURGICAL HISTORY
(PLEASE WRITE DATE NEXT TO ENTRY)

☐ HEART SURGERY: STENT/CABG/VALVE/PACEMAKER
☐ ARTHROSCOPY: KNEE/HIP/SHOULDER
☐ CARPAL TUNNEL SURGERY (WRIST)
☐ CUBITAL TUNNEL SURGERY (ELBOW)
☐ GASTRIC BYPASS
☐ HIP REPLACEMENT **R/ L**
☐ KNEE REPLACEMENT **R/ L**

☐ CERVICAL (NECK) SURGERY _____
☐ LUMBAR (BACK) SURGERY_____
☐ SPINAL CORD STIMULATOR
☐ OTHER_____

PLEASE TURN OVER TO COMPLETE….

NAME: _____

REGARDING THE PROBLEM THAT YOU ARE HERE TO SEE THE DOCTOR FOR:

IF YOU HAVE PAIN, WHERE IS IT THE WORST?

WAS IT CAUSED BY A SPECIFIC INCIDENT OR ACCIDENT?

APPROXIMATELY WHEN DID YOUR SYMPTOMS START?

OVERALL, IS YOUR PAIN THE SAME, BETTER OR WORSE THAN IT BEGAN?

IF YOU HAVE PAIN, DO SYMPTOMS RADIATE OR MOVE ELSEWHERE? IF SO, WHERE?

WHAT MAKES THE SYMPTOMS WORSE?

WHAT MAKES THE SYMPTOMS BETTER?

HAVE YOU EVER HAD A NERVE AND MUSCLE TEST (EMG/ELECTROMYOGRAM) BEFORE? IF SO, WHEN AND WHERE?

WHAT CONSERVATIVE TREATMENTS HAVE BEEN TRIED <u>FOR THIS PROBLEM</u>:

☐ OVER THE COUNTER PAIN RELIEVERS (NSAIDS, TYPE)
☐ TOPICAL MEDICATION
☐ ICE OR HEAT
☐ SPLINTS/BRACES/WALKER
☐ HOME EXERCISE PROGRAM
☐ CHIROPRACTIC CARE
☐ ACUPUNCTURE/MASSAGE
☐ ACTIVITY MODIFICATION

HOW MANY WEEKS IN TOTAL HAVE YOU TRIED CONSERVATIVE MEASURES? _____

☐ PHYSICAL THERAPY WHERE?_____ WHEN/FOR HOW LONG?_____

☐ INJECTION(S) WHERE?_____ WHEN? _____

☐ RECENT IMAGING WHERE WAS IT DONE? _____