Medical History (page one of six)

We ask that you complete this form to help the doctor determine your diagnosis and treatment plan. **Please be very specific.** Much of this information will also be vital in processing **your insurance claim.** ***Please answer every question even if your answer is "no" or "NA" (not applicable).***

Name (Please print in ink throughout this form) Today's date

Date of birth (month, date, year) Height Weight

Chief Complaint

1. What kind of symptoms are you having?

Present Illness or Condition

2. How long have you had these symptoms? (Be specific about when symptoms started.)

3. **If your symptoms are related to any injury, please mark the box below indicating the type of injury. Date of injury:_____**

   ☐ auto injury ☐ personal injury ☐ work-related injury ☐ not applicable

   Describe the accident and injury completely. If work-related, please tell why.

4. Please circle a number from 1 to 10 that most closely measures the level of pain you feel **consistently**.

hardly noticeable *noticeable and wearing* *I can barely tolerate it*

Medical History (page two of six)

Name (Please print in ink throughout this form) Date

Present Illness or Condition, continued

5. Please circle a number from 1 to 10 that most closely measures the level of pain you feel **on and off**.

6. Do you have any numbness or tingling in your arms or legs? ☐ yes ☐ no
(If yes, please describe and tell us *which side* is affected.)

7. Do you have any weakness in your arms or legs? ☐ yes ☐ no
(If yes, please describe and tell us *which side* is affected.)

Conservative Care History

Please provide ***detailed*** information about the treatments you have tried in order to relieve your symptoms.

Your insurance provider may deny authorizing surgery if they determine the information you provide is incomplete or does not meet their requirements for authorizing surgery.

8. Please check any of the following treatments you have tried to relieve your symptoms.

☐ heat	☐ reduction of activity	☐ cervical or lumbar traction
☐ chiropractic treatment	☐ work-hardening program	☐ cervical collar
☐ physical therapy	☐ exercise program	☐ back brace
☐ massage therapy	☐ pain-control clinic	☐ TENS unit
Treatment results _____		☐ others: _____

9. **Physical therapy (PT)** ☐ I have not had any PT

Describe the type of PT you have experienced _____

Name of the PT facility _____

Start date _____ End date _____ ☐ Still taking

Treatment results _____

10. **Pain medication** ☐ None taken

Name of medication _____

Dosage _____

Start date _____ End date _____ ☐ Still taking

Treatment results _____

Medical History (page three of six)

Name (Please print in ink throughout this form) Date

Conservative Care History, continued

11. **Anti-inflammatory medication** ☐ None taken

Name of medication _____

Dosage _____

Start date _____ End date _____ ☐ Still taking

Treatment results _____

12. **Muscle relaxants** ☐ None taken

Name of medication _____

Dosage _____

Start date _____ End date _____ ☐ Still taking

Treatment results _____

13. ***ORAL* steroids** ☐ None taken

Name of medication _____

Dosage _____
Number of pills Weight/volume in mg of the pill How many times per day?

Start date _____ End date _____ ☐ Still taking

Treatment results _____

14. **Steroid *INJECTIONS*** ☐ I have not had any steroid injections

Start date _____ End date _____ ☐ Still taking

How many times have you had steroid injections?_____ Time between each _____

Name of the provider who performed the injection(s) _____

Treatment results _____

Past Medical History

15. ***Please check the box if you have experienced any of the following in the past 5 years.***

☐ Anemia	☐ Gallbladder disease	☐ Peptic ulcer
☐ Arthritis	☐ Glaucoma	☐ Pneumonia
☐ Asthma	☐ Heart murmur	☐ Any prostate issues
☐ Autoimmune disease	☐ High blood pressure	☐ Respiratory disorder
☐ Blood clot	☐ High cholesterol	☐ Seizure disorder
☐ Cancer	☐ Kidney infection	☐ Sinusitis
☐ Coronary heart disease	☐ Kidney stones	☐ Thyroid disorder
☐ COPD	☐ Osteoporosis	☐ Urinary tract infection
☐ Diabetes mellitus	☐ Pacemaker	☐ None of these apply to me

Medical History (page four of six)

Name (Please print in ink throughout this form) Date

Past Medical History, continued

16. Please describe any other major medical conditions you have experienced in your lifetime.

Current Medications

17. Please list all current medications and the reason (diagnosis) for taking them.

	Medication	Reason for taking medication
A.		
B.		
C.		
D.		
E.		
F.		

My preferred ***local*** pharmacy is:_____ ( ) _____
(Please **do not** list an online or mail-order supplier, nor your doctor's name.) Phone number with area code of ***local*** pharmacy.

18. Do you take ALEVE, ADVIL, MOTRIN, IBUPROFEN, NAPROSYN, RELAFEN, ORUVAIL, or any other anti-inflammatory medicine? ☐ yes ☐ no If so, please list.

19. Do you take ASPIRIN? ☐ yes ☐ no If so, do you take ASPIRIN ☐ daily ☐ as needed?

20. Do you take COUMADIN (WARFARIN), PLAVIX, PRADAXA, HEPARIN, LOVENOX, AGGRENOX, or any other blood thinners? ☐ yes ☐ no If so, please list.

21. Do you take any supplements, herbs, or vitamins? ☐ yes ☐ no If so, please list.

Past Surgeries

22. Have you ever had any brain or spine surgery? ☐ yes ☐ no
If so, please give dates, reasons, and name(s) of surgeon(s).

Date	Reason	Name of surgeon
Date	Reason	Name of surgeon
Date	Reason	Name of surgeon

Medical History (page five of six)

Name (Please print in ink throughout this form) Date

Past Surgeries, continued

23. Please list ***ANY*** other past operations you have undergone during the last 10 years. Please give dates if you remember them. ☐ No other surgeries in the past 10 years.

A. _____ C. _____

B. _____ D. _____

Allergies

24. Please list ***ANY*** medications to which you are **allergic**. ☐ No known medication allergies

A. _____ C. _____

B. _____ D. _____

25. Are you allergic to IODINE? ☐ yes ☐ no ☐ don't know

26. Are you allergic to LATEX? ☐ yes ☐ no ☐ don't know

Social History

27. Do you smoke? ☐ yes ☐ no If so, how much? _____

28. Do you drink alcohol? ☐ yes ☐ no If so, how much and what kind? _____

29. Marital status: ☐ Single ☐ Married ☐ Significant other ☐ Legally separated ☐ Divorced ☐ Widowed

30. Where do you work?

_____
Employer name Address Phone number

31. Are you working now? ☐ yes ☐ no If you are working, what are the physical requirements of your job? Do you sit at a desk all day or perform physical labor? Please describe what you do physically during your work day.

Specifically, what amount and kind of lifting, if any, are you required to do?

Do you have any medical work-related restrictions? ☐ yes ☐ no (Please describe.)

32. If you stopped working because of symptoms related to this injury, when did you stop working?

33. Why did you stop working?

Medical History (page six of six)

Name (Please print in ink throughout this form) Date

Review of Systems

34. ***Please check the box if you have experienced any of the following in the past 5 years.***

- ☐ Corrective lenses
- ☐ Double vision
- ☐ Blurry vision
- ☐ Blindness
- ☐ Other Eye Symptoms
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Difficulty swallowing
- ☐ Other Otolaryngeal Symptoms
- ☐ Chest pain/discomfort
- ☐ Fast heart rate
- ☐ Other Cardiovascular Symptoms
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Other Pulmonary Symptoms
- ☐ Neck pain
- ☐ Back pain
- ☐ Headache
- ☐ Difficulties in speech
- ☐ Memory lapses or loss
- ☐ Motor disturbances
- ☐ Seizures
- ☐ Dizziness
- ☐ Other Neurological Symptoms
- ☐ Pain in the arms
- ☐ Pain in the leg
- ☐ Other Musculoskeletal Symptoms
- ☐ Easy bleeding
- ☐ Easy bruising tendency
- ☐ Other Hematologic Symptoms
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep disturbances
- ☐ Feeling restless/agitated
- ☐ Claustrophobia
- ☐ Other Psychological Symptoms
- ☐ Weight change
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Abnormal appetite
- ☐ Other Constitutional Symptoms
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black/bloody stools
- ☐ Abdominal pain
- ☐ Other Gastrointestinal Symptoms
- ☐ Pain w/urination
- ☐ Bloody urine
- ☐ Loss of control (leaking)
- ☐ Urination at night
- ☐ Other Genitourinary Symptoms