

Initial Patient Evaluation

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In order to utilize our time efficiently, please complete the following as best you can in the space provided.

NAME: _____ PAT# _____ DATE: _____

AGE: _____, Right/ Left handed, Female/ Male. Referred by Self- _____

Reason for visit: _____

ONSET: was gradual/ sudden (Date?) _____ & is felt due to _____

DURATION: Constant/ Intermittent. _____

The primarily location of pain is in the Neck/ Arm/ Back/ Buttock/ Leg/ _____

It is made worse by _____

It is made better by _____

OTHER SYMPTOMS: numbness/ weakness/ incontinence/ sleep problems/ none

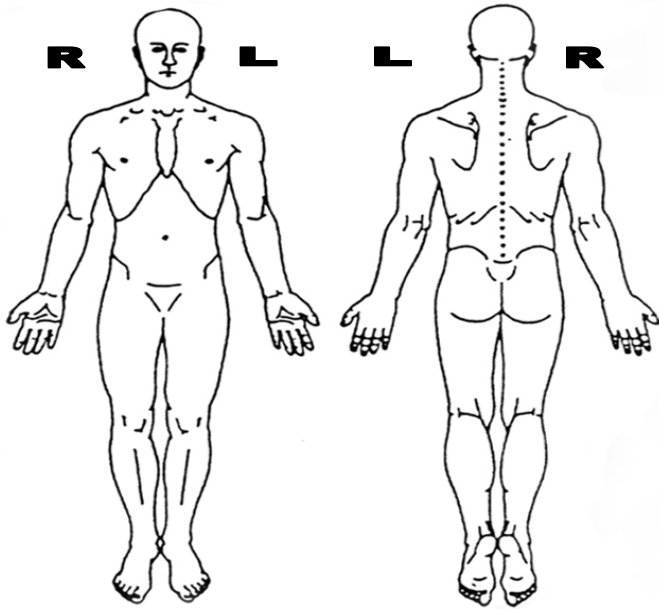
PRIOR TREATMENT: Please note prior treatments and their effectiveness.

Have you ever had this type of problem before? _____

Please indicate on the following scale the **Severity** of your pain. The scale is “0” (no pain at all) to “10” (such severe pain you are unable to function –i.e. Drive, talk on phone, eat because the pain stops you from doing the task) **Please place an “x” on the line where you feel best represents your pain: 1) at its least, 2) at its worst, 3) now.**

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
(No pain) (Moderate pain) (Severe pain)

Please shade on the diagrams below areas of your pain.
 Please use the symbols shown NNN to indicate areas of numbness.



- Circle the words that apply to your pain**
- Aching
 - Throbbing
 - Shooting
 - Stabbing
 - Gnawing
 - Sharp
 - Tender
 - Burning
 - Exhausting
 - Tiring
 - Penetrating
 - Nagging
 - Numb
 - Miserable
 - Unbearable
- _____
- _____
- _____

Please do not write in this area.

Please Continue on the back side

Please complete all of the following sections

Name: _____
Pat #: _____ Date: _____

PMH: Please check all Medical problems of the below that apply to you:

- Anemia
- Angina
- Arthritis: RA/ OA/ Gout
- Asthma
- Atrial Fibrillation
- Back Ache
- Blood Clots
- Bronchitis / COPD /
- Emphysema
- Heart Attack /Disease
- Congestive Heart Failure
- Kidney Disease
- Cancer: _____
- Colitis/ Irritable Bowel
- Stroke / Mini Stroke
- Depression /Anxiety
- Diabetes
- Fracture- _____
- Stomach problems:
Reflux /Gastritis /Ulcers
- Bleeding from stomach /gut
- Eye Disease: _____
- Hyperlipidemia
- High blood pressure
- Hernia: _____
- Thyroid Disease
- Liver Disease / Hepatitis
- Lupus
- Neuropathy
- Obesity
- Osteoporosis
- Parkinson's
- Pulmonary Embolus
- Pneumonia
- Seizure / Epilepsy

Checks are positive

PSH: Please check all surgeries of the below that apply to you.

- Appendectomy
- Cataracts
- Gallbladder surg
- Hysterectomy
- Heart Surgery
- _____
- Pacemaker
- Tonsillectomy
- Thyroidectomy
- Vascular Surg.
- _____
- Hip Surgery
- _____
- Knee Surgery
- _____
- Neck Surgery
- _____
- Back Surgery
- _____
- Other:
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Checks are positive

ROS: Please circle any of the below that apply to you:

- Cons:** Fever/ Chills /
Weight loss/ Fatigue/
Sleep difficulty
- Eyes:** Redness/ Dry/
Tearing/ Vision changes
- Throat:** Soreness /
Difficulty swallowing
- CV:** Abnormal pulse/
Chest pain/ Swelling
- Pulm:** Short of breath /
Cough/ Wheeze
- GI:** Nausea/ Vomiting,
Abdominal pain/
Reflux/ Heart burn /
Constipation/ Diarrhea
- Urine:** Incontinence /
Pain/ Urgency/
Frequency
- Musc:** Muscle pain /
Joint pain/ Stiffness /
Neck pain/ Back pain /
muscle cramps /
- Neuro:** Weakness /
Tingling/ Numbness /
Seizures/ Head ache
- Psych:** Depression/
Anxiety/ Psychosis
- Skin:** Rash/ Hair loss/
Sun Sensitive/ Ulcers
- Endo:** Thirst/ Hungry/
Hot or Cold Intolerance
- HEM/Lymph:** Bleeding
Bruising/ Anemia /
Swollen glands /
Thrombosis

All other systems review Negative

Please list all your current medications. Please include all **Prescription and Nonprescription** medications you take.
 See attached sheet

Please list medication Allergies: None

FMH: Please list Medical History for your Mother, Father, & Brothers / Sisters. (i.e., Heart disease, High Blood Pressure, Diabetes, Stroke, Thyroid Disease, etc.)
Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Social Hx: Who do you live with?: Spouse / Alone / Other family _____

Do you live in a: House / Apartment / Mobile home /Assisted Living / Nursing facility? _____
Please Describe your routine day over the last week: _____

Please rate your ability to perform the following tasks, as: **Yes I can do it = Y**, **Yes with increased pain = WP**, **Unable to do = N**

Getting in/out of bed **Y WP N** Toileting **Y WP N** Bathing **Y WP N** Dress self **Y WP N** Fix meals **Y WP N**
Feed self **Y WP N** Home Care **Y WP N** Walk in home **Y WP N** Walk 1 block **Y WP N** Walk 1 mile **Y WP N**
Shopping **Y WP N** Driving **Y WP N**

Do you have a job? **Y/ N** Are you currently working? **Y/ N** Current work status: Full Duty/ Light Duty/ Off
Please list usual work activities. _____

Are there any lawsuits related to the reason for this visit? **Y/ N** Is this visit WorkComp related? **Y/ N**
Do you use tobacco? **Y/ N** If so, how much? _____ For how long? _____
Do you drink any alcohol? **Y/ N** If so, how much? _____ For how long? _____
Have you used any illicit drugs? (Marijuana, Cocaine, Heroine, other) **Y/ N** _____



MEDICATION RECONCILIATION

Date: _____ **Patient's Name:** _____

DOB: _____ **Medical Record #:** _____

No Known Drug Allergies **Allergies/Reactions:** _____

***LIST ALL THE MEDICATIONS THAT YOU ARE TAKING, INCLUDING SUPPLEMENTS, OVER THE COUNTER, INHALERS, EYE DROPS, AND HERBALS**

Patient is not taking any medications

Medication/ Supplement/ Over the Counter	Dosage e.g. mg, unit, mcg	How is the Medication Taken (e.g. oral, injection)	How often is the Medication Taken (e.g. daily, twice daily)	Prescribing Physician