

HISTORY AND PHYSICAL

Name: _____ Date: _____ Age: _____ Sex: M / F

Referring Physician: _____ Allergies: _____

Location of Pain: _____

How long have you had this pain?: _____

Did you have an injury that caused this pain? _____

(Circle one): Is the pain constant or intermittent? Pain Rating (1-10) _____

What increases the pain? _____ What decreases the pain? _____

(Circle any that apply) Describe the pain: Burning Aching Gnawing Stabbing Sharp Dull

Other: _____

List any medications that you take consistently: _____

Past Medical History:

	Yes	No		Yes	No		Yes	No
Heart Disease	___	___	Bleeding	___	___	Kidney Disease	___	___
Diabetes	___	___	Liver Disease	___	___	Stomach/Colon	___	___
Lung Disease	___	___	High Blood Pressure	___	___	Neurologic Disease	___	___

Have you ever had any past surgeries? (Circle one) Yes No If yes, please explain below.

Any surgeries on your spine? (Circle one) Yes No If yes, when _____

Have any of your immediate family members had any of the above health problems that we have asked you about?

(Circle one) Yes No If yes, please explain: _____

Social History:

Do you drink alcohol? (Circle one) Yes No If yes, # of Drinks per Day/Week/or Month _____

Do you use tobacco? (Circle one) Yes No If yes, (Circle one) Cigarettes # of packs per day _____

Cigars How often? _____

Chewing Tobacco How much? _____

What are your habits regarding Sports/Exercise? _____

Are you (Circle one) Married Single Divorced Widowed

Do you live alone? (Circle one) Yes No

For Office Use Only

BP _____ LA RA P _____ R _____ Temp _____ Weight _____

MRI _____ X-RAYS _____ MEDICAL RECORD _____

Prior Pain Treatment _____