S · O · A · R
THE TEAM APPROACH
Affiliated with Verity Medical Foundation

The Physiatry Medical Group
San Francisco Redwood City San Jose

Name:

MR#:

DOB: **Date:**

E-mail:

☐ Dr. Jeffrey Saal ☐ Dr. Joel Saal ☐ Dr. Robert Gamburd

☐ Dr. Robert Millard ☐ Dr. Neeti Bathia ☐ Dr. Christopher Bonzon **Referred From:**

Please Complete Diagram:

Key:

///-Stabbing

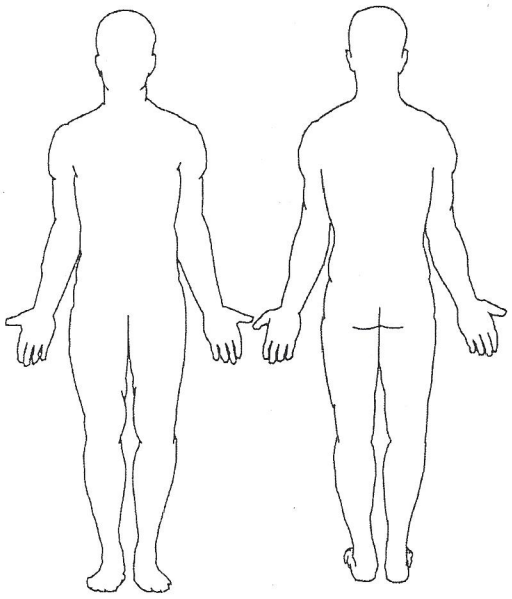
XXX-Burning

OOO-Pins and Needles

===-Numbness

+++-Aching

TTT-Weakness



Rate Your Pain

0=No Pain **10**=Extreme Pain

1. Right Now: 0 1 2 3 4 5 6 7 8 9 10
2. At Best: 0 1 2 3 4 5 6 7 8 9 10
3. At Worst: 0 1 2 3 4 5 6 7 8 9 10

What makes your pain better?

☐ Ice ☐ Heat ☐ Medication

☐ Stretching ☐ Other _____

What Makes Your Pain Worse?

☐ Sitting ☐ Standing ☐ Walking

☐ Bending/Twisting ☐ Other _____

Pharmacy Name: _____ **City/Street:** _____

Primary Care Physician

Name: **Phone:**

☐ Please check here if you would like us to send copies of your notes to your primary care physician

Social History

Height: _____ Weight: _____ **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Work Status: ☐ Full Time ☐ Part-Time ☐ Not Working ☐ Student ☐ Retired

Occupation: _____

School: _____ **Grade:** _____

Do you play sports? ☐ Yes ☐ No **If so what sports?** _____

Tobacco Use: ☐ Never ☐ Former: When did you quit: _____ ☐ Current: How may per day: _____

Alcohol Use: ☐ None ☐ Rare ☐ Occasional ☐ Moderate ☐ Heavy

S·O·A·R
THE TEAM Asthma
Affiliated with Verity Medical Foundation

MAJOR MEDICAL CONDITIONS

☐ Hypertension ☐ High Cholesterol ☐ Diabetes: Type 1 / 2 ☐ Glaucoma ☐ Depression

☐ Cancer _____ ☐ Other _____

ALLERGIES

- Do you have any drug allergies? ☐ Yes ☐ No

  Medication: _____ Reaction: _____

- Do you have an allergy to contrast dyes? ☐ Yes ☐ No
- Do you take aspirin or any blood thinners daily? ☐ Yes ☐ No
- Are you allergic to anything else we should be aware of (i.e. Shellfish, latex, etc) _____

MEDICATIONS

Medication	Strength/Dose	Frequency

MAJOR SURGIERIES/YEAR

☐ Appendectomy _____ ☐ Back Surgery _____ ☐ Breast Surgery _____ ☐ Hip (Left/Right) _____

☐ Hysterectomy _____ ☐ Tonsillectomy _____ ☐ Prostate Surgery _____ ☐ Other _____

Major Family History

☐ Yes ☐ No

If yes: please elaborate _____

Have you had any of the following test or treatments for this problem?

TESTS	NO	YES	TREAMENTS	NO	YES	DATES
MRI	☐	☐	PHYSCIAL THERAPY	☐	☐	_____
C/T SCAN	☐	☐	CHIROPRACITC CARE	☐	☐	_____
X-RAY	☐	☐	ACUPUNCTURE	☐	☐	_____
EMG	☐	☐	HOME EXERCISE PROGRAM	☐	☐	_____