



Name: _____

MR#: _____

DOB: _____

Date: _____

E-mail: _____

Referred From: _____

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

Dr. Robert Millard Dr. Neeti Bathia Dr. Christopher Bonzon

Please Complete Diagram:

Key:

///-Stabbing

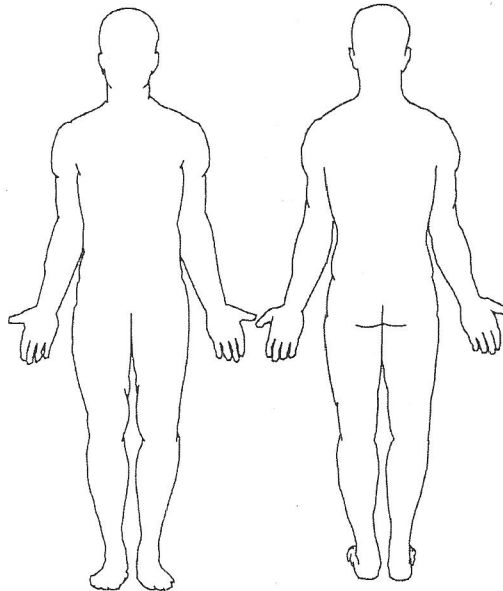
XXX-Burning

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



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?

<u>TESTS</u>	<u>NO</u>	<u>YES</u>	<u>TREATMENTS</u>	<u>NO</u>	<u>YES</u>	<u>DATES</u>
MRI	<input type="checkbox"/>	<input type="checkbox"/>	PHYSICAL THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	_____
C/T SCAN	<input type="checkbox"/>	<input type="checkbox"/>	CHIROPRACTIC CARE	<input type="checkbox"/>	<input type="checkbox"/>	_____
X-RAY	<input type="checkbox"/>	<input type="checkbox"/>	ACUPUNCTURE	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMG	<input type="checkbox"/>	<input type="checkbox"/>	HOME EXERCISE PROGRAM	<input type="checkbox"/>	<input type="checkbox"/>	_____