



**PATIENT INFORMATION**

Patients Name (Last, First, Middle Initial): \_\_\_\_\_

Sex: M  F  Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SSN: \_\_\_/\_\_\_/\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Consent to Text:  Yes  No

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status: (Check one)  Single  Married  Widowed

Preferred Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Temp: \_\_\_\_\_

**REFERRAL INFORMATION**

So that we may keep your referring physician and primary care physician informed of your progress under our care, please complete below. If you do not want your records forwarded to this physician, please notify us.

Who is the referring physician that referred you to AllSpine Care? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PATIENT INFORMATION OF DIAGNOSIS**

Briefly describe your main problem/complaint: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ How long have you had this problem: \_\_\_\_\_

Where did it occur?  Auto  Work  Home  School Other: \_\_\_\_\_

Were you treated in the ER?  Yes  No Which hospital? \_\_\_\_\_ Date: \_\_\_\_\_

Attorney Name (if applicable): \_\_\_\_\_ Tel# \_\_\_\_\_

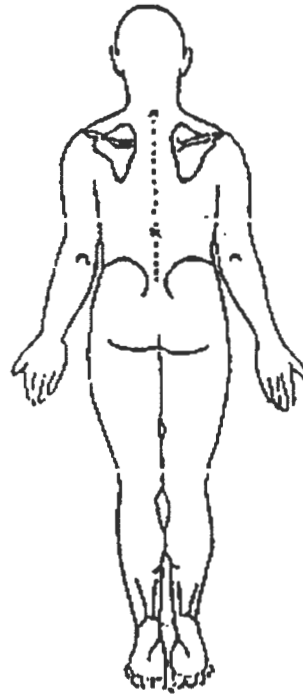
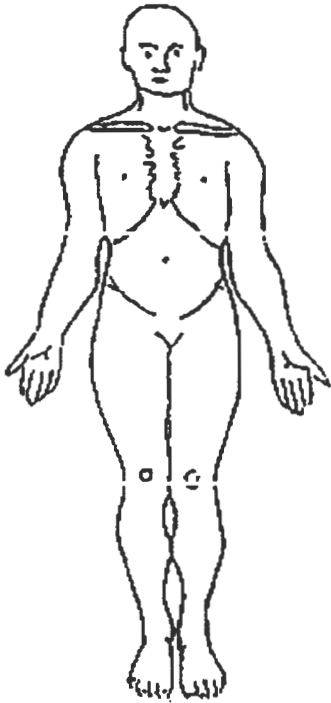
Using the symbols below, please draw the location of your symptoms on the diagram and rank your pain level from a 1 to 10.

XXX Pain

0000 Numbness

//// Aching

\*\*\*\* Pins & Needles



If you have NECK PAIN, what percentage of your pain is \_\_\_\_\_% Neck and \_\_\_\_\_% Arm (Total 100%)

If you have BACK PAIN, what percentage of your pain is \_\_\_\_\_% Back and \_\_\_\_\_% Leg (Total 100%)

Mark an X on the line indicating the usual Degree of the Pain (0 meaning No Pain, 10 meaning Worst pain) 0 \_\_\_\_\_ 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 7 \_\_\_\_\_ 8 \_\_\_\_\_ 9 \_\_\_\_\_ 10

What position/activity makes the pain worse/better? Examples include: *bending, twisting, walking, laying down, sitting, standing, etc.*

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How long can you STAND with no or minimal pain \_\_\_\_\_ minutes.

WALKING DISTANCE with no or minimal pain: \_\_\_ 0-50ft \_\_\_ 50-200ft \_\_\_ 200-500ft \_\_\_ 500+ ft \_\_\_ 1/2 mile+

Do you need SUPPORT to help you walk?  Yes  No If yes, type of support? \_\_\_\_\_

Do you wear a back or neck BRACE?  Yes  No If yes, type of brace? \_\_\_\_\_

Indicate which **DIAGNOSTIC TESTS** you have had in evaluation of your main complaint/problem (**include dates**).  
Examples include: *X-ray, MRI, bone scan, myelogram, etc.*

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Indicate which **TREATMENTS** you have had in evaluation of your main complaint/problem and if they were helpful: *Physical therapy, Chiropractic care, Pain Management, Injections, etc.*

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**PRESCRIPTION HISTORY**

List **ALL CURRENT MEDICATIONS** below:

<u>Name</u>	<u>Dose (milligrams, grams)</u>	<u>Frequency</u>	<u>Duration</u>

Pharmacy Name/Location: \_\_\_\_\_ Phone: \_\_\_\_\_

List Any Known Drug Allergies w/reactions:

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Food or Metal Allergy: \_\_\_\_\_

**FAMILY HISTORY**

Please list any illnesses, medical conditions or death of immediate family members:

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**SOCIAL HISTORY**

Do you currently use tobacco products? (includes vaping products)  Yes  No

If yes, quantity: \_\_\_\_\_

If past smoker, when did you quit? \_\_\_\_\_ What was past quantity? \_\_\_\_\_

Have you ever been treated for drug and/or alcohol abuse?  Yes  No

Highest Level of Education Received: \_\_\_\_\_

**SURGICAL HISTORY**

List any **MAJOR EVENTS OR SURGERIES** you have had by type, date and outcome:

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**PAST MEDICAL HISTORY**

Bowel Disorders	<input type="checkbox"/>		Osteoporosis	<input type="checkbox"/>	
Cancer (Where)	<input type="checkbox"/>		Pacemaker	<input type="checkbox"/>	
Depression	<input type="checkbox"/>		Polio	<input type="checkbox"/>	
Diabetes (I or II)	<input type="checkbox"/>		Psoriasis	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>		Rheumatism	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>		Seizures	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>		Serious Infection	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	
Lung Disease	<input type="checkbox"/>		Thyroid	<input type="checkbox"/>	
Multiple Myeloma	<input type="checkbox"/>		Ulcers	<input type="checkbox"/>	
OTHER:	<input type="checkbox"/>			<input type="checkbox"/>	

### Review of Systems (ROS)

(Please complete the form by checking the boxes that you have current concerns about.)

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

<b>Constitutional</b>	<input type="checkbox"/> Fever <input type="checkbox"/> Significant weight change <input type="checkbox"/> Significant appetite change	<b>Urology</b>	<input type="checkbox"/> Frequent urination <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Pain with urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Urinary urgency
<b>Eye</b>	<input type="checkbox"/> Vision problems <input type="checkbox"/> Eye irritation <input type="checkbox"/> Eye pain	<b>Musculoskeletal</b>	<input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Low back pain <input type="checkbox"/> Neck pain
<b>ENT</b>	<input type="checkbox"/> Nosebleeds <input type="checkbox"/> Cold symptoms <input type="checkbox"/> Voice changes <input type="checkbox"/> Hearing problems	<b>Neurology</b>	<input type="checkbox"/> Chronic headache <input type="checkbox"/> Passing out <input type="checkbox"/> Confusion <input type="checkbox"/> Seizures <input type="checkbox"/> Dizziness
<b>Respiratory</b>	<input type="checkbox"/> Chronic cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Loud snoring /stop breathing when sleeping	<b>Dermatology</b>	<input type="checkbox"/> Rash <input type="checkbox"/> Worrisome moles <input type="checkbox"/> Skin lesions
<b>Cardiovascular</b>	<input type="checkbox"/> Chest pain <input type="checkbox"/> Leg swelling <input type="checkbox"/> Palpitations (racing heart or skipped beats)	<b>Mental Health</b>	<input type="checkbox"/> Sadness <input type="checkbox"/> Feeling anxious <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Do you feel unsafe?
<b>Gastroenterology</b>	<input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stools	<b>Endocrinology</b>	<input type="checkbox"/> Feeling too cold or too hot <input type="checkbox"/> Frequently thirsty
<b>Male Reproductive</b>	<input type="checkbox"/> Concern for Sexually Transmitted Disease (STD) <input type="checkbox"/> Testicular lump/pain <input type="checkbox"/> Penile discharge or lump <input type="checkbox"/> Problems with sexual function	<b>Hematology – Oncology</b>	<input type="checkbox"/> Swollen glands <input type="checkbox"/> Easy bruising
<b>Female Reproductive</b>	<input type="checkbox"/> Concern for Sexually Transmitted Disease (STD) <input type="checkbox"/> Breast lumps, breast concerns <input type="checkbox"/> Abnormal vaginal discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Menstrual cycle concerns	<b>Additional Information</b>	I have an Advance Directive <input type="checkbox"/> Yes <input type="checkbox"/> No  I am an Organ Donor <input type="checkbox"/> Yes <input type="checkbox"/> No  I am interested in discussing: <input type="checkbox"/> Advance Directive <input type="checkbox"/> Organ donation

List below **PREVIOUS PHYSICIANS** (MD, DO, Chiropractor) you have seen for your main complaint/problem.

Physician	Specialty	Dates	Treatment

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**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_