Date:

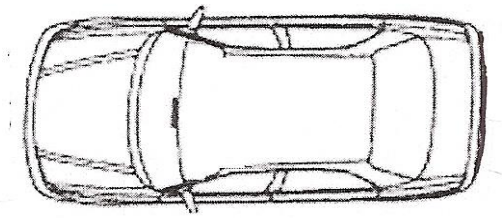
COMPREHENSIVE SPINE CENTER

Name: _____ Age: _____ DOB: _____/____/_____
Last First
Occupation: _____ Work Related Injury Motor Vehicle Accident Slip and Fall
Hand Dominance: RT LT Date of Injury: _____/_____/_____
REASON FOR VISIT: _____

Seat Belt Air Bag Head Injury LOC
ER Visit: YES NO When: _____ Transported How: _____

Tx prior to 1st medical appointment: _____
1st therapy treatment date: _____ Where: _____

F R O N T



B A C K

CIRCLE IF ANY APPLY:

Headaches	FRT	BK	RT	LT
Neck Pain	RT	CNT	LT	
Low Back Pain	RT	CNT	LT	
Shoulder Pain	RT	LT		
Hip Pain	RT	LT		
Other				

Chiro. Treatment / PT: _____ Times a week
If completed when: _____

Pain Meds: _____ _____
_____ _____

Brace: _____

Missed work due to accident: Yes No
How many days: _____

Imaging: _____
_____
_____

Pain specialist: Y N Ortho Specialist: Y N
Procedure types: _____
_____

Previous Accidents/ Trauma: Y N

Explain: _____

Prior to the accident have you suffered from previous pain or injury to the recently injured body parts: Y N

Explain: _____

BP _____ PULSE _____ HT _____ WT _____ GLUCOSE _____ Plan:
(***Physician/PA Use Only***)

1.) _____
2.) _____
3.) _____
4.) _____
5.) _____

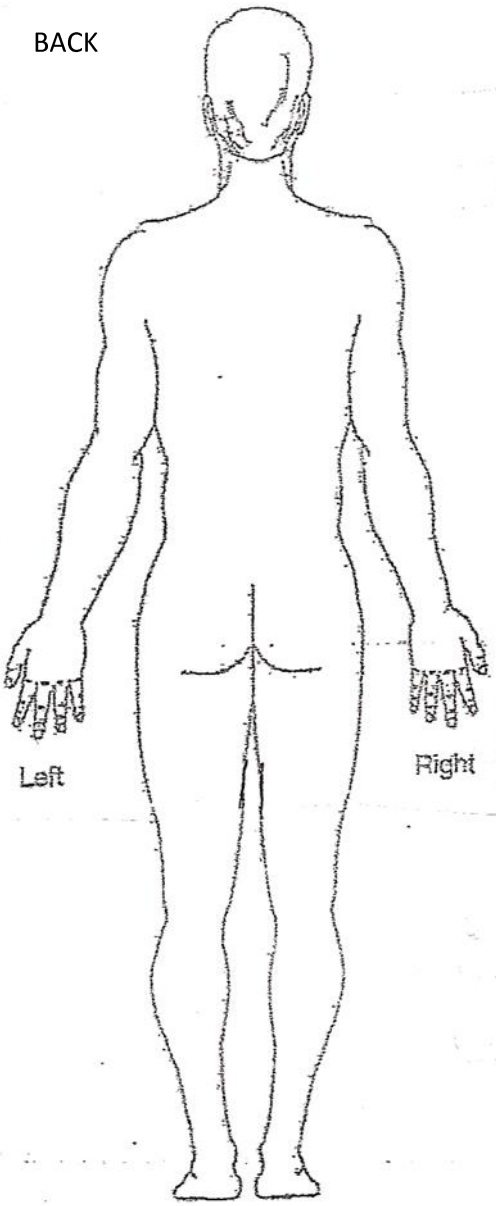
Patient Initials _____
Provider Initial _____

COMPREHENSIVE SPINE CENTER

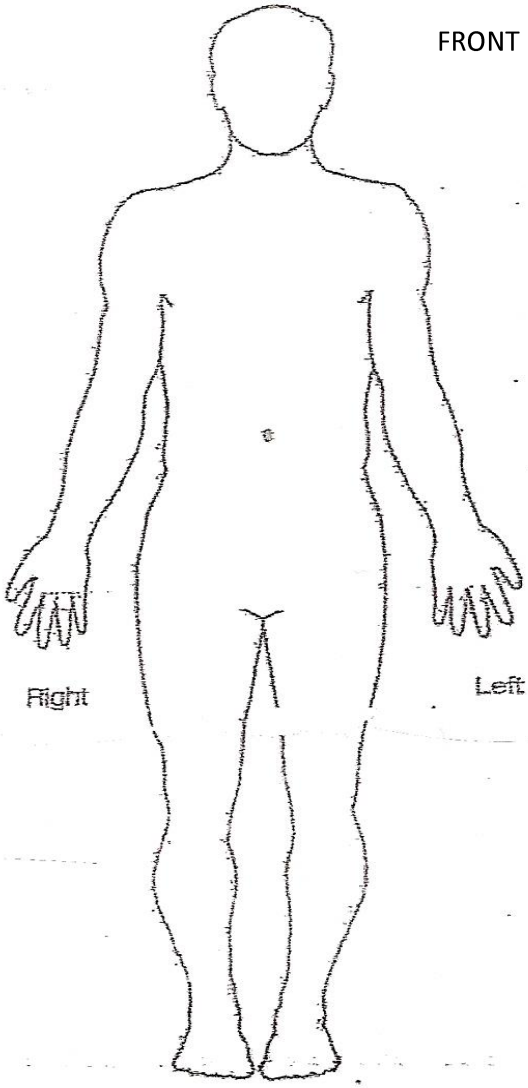
PATIENT PAIN DRAWING

Mark the areas on your body where you feel the described sensations.

BACK



FRONT



Patient Initials _____

Provider Initial _____

COMPREHENSIVE SPINE CENTER
PATIENT HISTORY

ALLERGIES

MEDICATION ALLERGIES 1. _____ 2. _____
OTHER ALLERGIES 1. _____ 2. _____

MEDICATIONS

List all of your current medications and dosages including over the counter medication, herbal Supplements and inhalers.

List Pain Medications/Dose 1._____ 2. _____

3._____ 4. _____

List Other Medications 1._____ 2. _____

3._____ 4. _____

5._____ 6. _____

7._____ 8. _____

PAST SURGICAL HISTORY (Circle and Give Dates of Surgery)

Neck Surgery	____/____/____	Knee Replacement	____/____/____	Shoulder Surgery	____/____/____
Back Surgery	____/____/____	Appendectomy	____/____/____	Cataracts	___/____/____
Tonsillectomy	____/____/____	Cardiac Sent	____/____/____	Gallbladder	___/____/____
Cardiac Bypass	____/____/____	Hysterectomy	____/____/____	Hip Replacement	___/____/____
Hernia	____/____/_____	Other	____/____/____	Other	____/____/___

SOCIAL HISTORY

Marital Status:	Married	Single	Divorced	Widowed
Children:	Yes	No	Number: _____	
Smoke	Yes	No	Amount _____	
Previously Smoke	Yes	No	Quit When? _____	
Alcohol Use	Never	Occasional	Moderate	Heavy
Drug Use	None	Presently	In the Past	
Education Attained:	Elementary	High School	Technical or Trade School	
	Some College	College Degree	Graduate School	
Exercise:	None	< 3 times a week	> 3 times a week	
Occupation:				

COMPREHENSIVE SPINE CENTER

PAST MEDICAL HISTORY

	GENERAL		**HEART**
	Cancer		Hypertension
	Hepatitis		Heart Attack
	Alcoholism		Chest pain / Angina
	Thyroid Problems		Heart Failure
	Hemophilia		Blood Clot DVT
	Fever		Heart Murmur
	Night sweats		Palpitations
	Sudden weight loss		Pacemaker
	Fatigue		
	Anxiety		**LUNGS**
	Depression		Shortness of Breath
	Major Injuries		COPD
			Asthma
	EYES/EARS/HEAD		Recurrent Bronchitis
	Migraine		Emphysema
	Glaucoma		Pulmonary Embolism
	Cataracts		TB
	Blindness		Pneumonia
	Contacts		
	Partial Plate/ Dentures		**URINARY TRACT**
	Hearing Loss		Kidney Failure
			Kidney Stones
	ABDOMEN		Recent Infections
	Peptic Ulcers		Prostate Disease
	Heartburn		Recurrent Bladder Infections
	Hernia		Recurrent Kidney Infections
	GERD		Bladder Control Problems
	Frequent Nausea		Dialysis
	Liver Cirrhosis		
			BONE/JOINTS
	ENDONDRINE		Gout
	Diabetes		Rheumatoid Arthritis
			Osteoarthritis
	NEUROLOGIC		Osteoporosis
	Alzheimer’s		
	Stroke		
	Seizure		
	Epilepsy		

COMPREHENSIVE SPINE CENTER

Anesthesia History

Date of Last Anesthetic _____/_____/_____

Have you ever had an adverse reaction problem with anesthesia? ☐Yes ☐No

If yes, explain: _____

Has a blood relative ever had and adverse reaction/problem with anesthesia? ☐Yes ☐No

Family History (Circle and indicate whether Mother Or Father)

Stroke	_____	Bleeding Disorder	_____	Alcoholism	_____
Heart Troubles	_____	Depression	_____	Cancer	_____
Hypertension	_____	Arthritis	_____	Blood	_____
Diabetes	_____	Mental Illness	_____	Other	_____

REVIEW OF SYSTEMS Check only the items you have or have had recently. Add items if not shown

CONSTITUTIONAL		**GU**	
	Weight loss		Incontinence
	Hot or Cold Spells		Frequent Urination
	Malaise		
	EYES		
	Reading Glasses	**SKIN AND BREAT**	
	Change in Vision		Rash
	Blurring Vision		Ulcers
			Masses
EARS/NOSE/THROAT		**ENDOCRINE**	
	Hearing Loss		Diabetes
	Hoarseness		Hypertension
	Vertigo		Night Sweats
			Hypoglycemia
CARDIOVASCULAR		**NEUROLOGIC**	
	Chest Pain		Hand Trembling
	Palpitations		Memory Loss
	Abnormal Heartbeat		Headaches
	Swollen Ankles		Gait Disturbances
RESPIRATORY		**PSYCH.**	
	Short of Breath		Depression
	Asthma		Insomnia
	COPD		Alcohol Abuse
	Cough		Drug Abuse
GI		**OTHER**	
	Hemorrhoids		
	Diarrhea		
	Constipation		
	Abdominal Pain		

**I hereby declare that the information disclosed in pages 1-6 of this packet is true and accurate.

Patient Initials _____

Provider Initial _____