

Patient Evaluation

1. Age _____
2. Right Left handed
3. Male Female Females: pregnant or nursing? _____
4. Your current/past occupation _____
5. Single Married Divorced Separated Widowed
6. Height _____ foot _____ inches
7. Weight _____ lbs
8. Who is going to be looking after you? _____
9. How many daughters do you have? _____ How old are they? _____
10. How many sons do you have? _____ How old are they? _____
11. Do you smoke? _____ How many packs a day? _____
When did you quit smoking? _____

What is the main **problem** that you want us to help you with? (pain, numbness, weakness)

Tell us more about this problem. How severe is it? Minor, moderate, severe
What is the exact location of the problem? (arms, legs, head, back)

When did the problem start? (date)

How did the problem start? (lifting, trauma)

When during the day or night does the problem occur or worsen?

What makes the problem worse? (standing, sitting, laying down, coughing)

What makes the problem better? (Medication, leaning over a cart while shopping)

List your other medical conditions (bleeding problems, heart attacks, infections, diabetes, hypertension, respiratory problems).

1. _____
2. _____
3. _____
4. _____

Name _____ DOB _____ ID _____

What surgeries, hospitalizations, trauma, have you had in the past? What year? Which hospital? Which surgeon?

1. _____
2. _____
3. _____
4. _____

Are you allergic to any medications, foods, x-ray or iodine contrast, adhesive tape, latex, rubber, or anything else?

1. _____
2. _____

List all medications (prescription, over the counter, herbal, etc) that you take. Please include the medication name, how many milligrams, how many times a day, and for what purpose you take it.

Medication	Dose	Frequency	Reason

Are there any of the following in your immediate family?

Heart disease ___ Cancer ___ Diabetes ___ Blood disorders ___
Neurological disorders (strokes) ___ Tuberculosis ___ Other ___

Do you drink alcohol? _____ Occasionally _____ daily _____ every week _____

Have you ever used the drugs listed? Marijuana, cocaine, heroine, other _____

Is this a workman's compensation case? _____

Is there a lawsuit planned, relating to your problem injury? _____

If yes, against whom? _____ Attorney _____

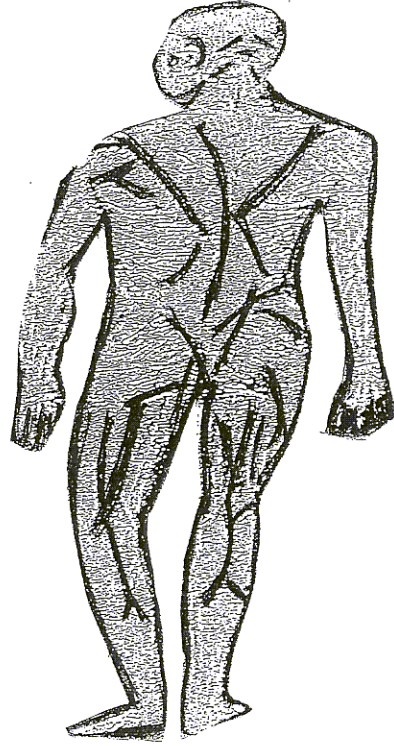
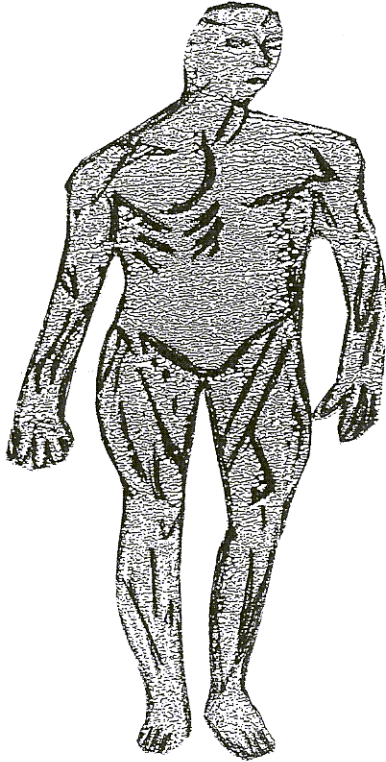
My signature signifies that I have read, answered, and understand the above information.

Patient/Guardian Signature _____ Date _____

Name _____ DOB _____ ID _____

Patient Evaluation and Management Services-History

Please outline the areas on your body where you feel the described sensations. Please indicate which feeling affects the outlined area: Numbness, Pins/Needles, Burning, Stabbing, Dull, and Aching.



Patient Signature

Date

Name _____ DOB _____ ID _____