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 All Spine 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: ____________________

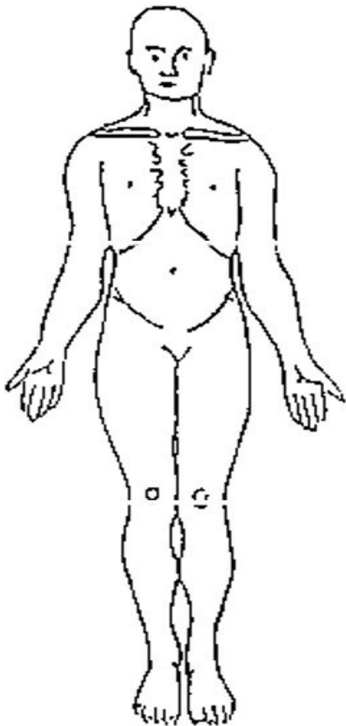
Where did it occur? ☐ Auto ☐ Work ☐ Home ☐ School Other: ___________________________

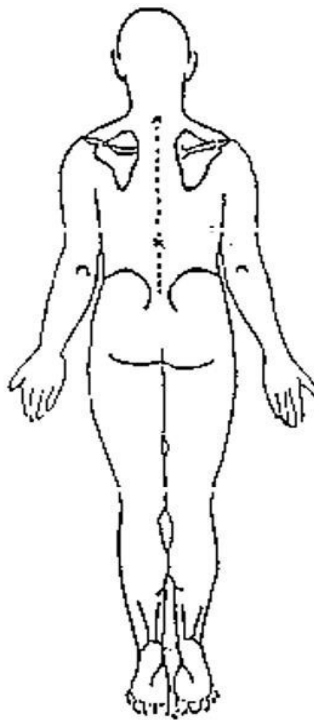
Were you treated in the ER? ☐ Yes ☐ No Which hospital?________________Date: _________

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.*

____

____

____

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*.

____

____

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.*

____

____

PRESCRIPTION HISTORY

List ***ALL CURRENT MEDICATIONS*** below:

Name	Dose *(milligrams, grams)*	Frequency	Duration

Pharmacy Name/Location:__________________________________**Phone:** _______________________

List Any Known Drug Allergies w/reactions:

____

____

Food or Metal Allergy: ____

FAMILY HISTORY

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

____

____

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:

____

____

____

PAST MEDICAL HISTORY

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

Review of Systems (ROS)

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

Today's Date: ____________________

Patient Name: ____ **DOB:** ________________

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

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

Physician	Specialty	Dates	Treatment

PATIENT SIGNATURE**____*****DATE*****______/______/_______**