Date: ________________

GENERAL INFORMATION:

Patient Name: ____

Age:________________Date of Birth: _______________

Weight:_____________Height:_____________________

Chief complaint or problema (Reason for Visit):
____

Date Problem began:
____

Pharmacy:
____

Pharmacy Phone:
____

Pharmacy Care Physician:
____

Have you had this problem before? Yes No

Medications you are currently taking

Prescription Name	Prescribed by:
1.	
2.	
3.	
4.	

Allergies: (e.g., Drug, Food)

Have you or are you currently taking drugs not prescribed to you: Yes No
If yes, describe:___________________________________

Immunizations Current: Yes No
(MMR, Hepatitis, Tetanus)

Prior Major Illnesses and Injuries

Surgical History

Type of Surgery/Procedure	Date/Year

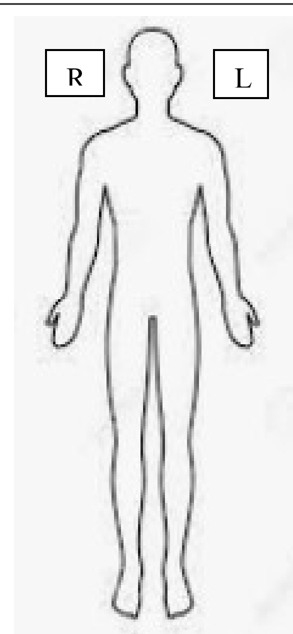
Tobacco Use: Yes No Occasionally Socially
Illegal Drugs: Yes No Occasionally Socially

Alcohol Use: Yes No Occasionally Socially

Is this problem the result of an injury: Y______N _____
If no, was it a gradual onset______or sudden onset _______ If yes, you MUST complete below:
Where did injury occur____
Date the injury occurred____
How did the injury occur?____
____

Work related: Y____N _____

Auto related: Y____N _____
Driver____Passenger______Pedestrian______
Type of vehicle ________________________________
What did you hit/hit you__________________________



Neck ◻	and **radiates** to	◻ R arm ◻ L arm ◻ Neither	Shoulder	◻ R ◻ L	Elbow	◻ R ◻ L	Hand	◻ R ◻ L	Pelvis	◻ R ◻ L	Knee	◻ R ◻ L	Foot	◻ R ◻ L
Back ◻	and **radiates** to	◻ R leg ◻ L leg ◻ Neither	Arm	◻ R ◻ L	Wrist	◻ R ◻ L	Finger T 2 3 4 5	◻ R ◻ L	Hip	◻ R ◻ L	Ankle	◻ R ◻ L	Toe B 2 3 4 5	◻ R ◻ L

On a scale of 0-10 (10 is the worst) how severe is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the **quality** of the pain? ◻ Sharp ◻ Dull ◻ Stabbing ◻ Throbbing ◻ Aching ◻ Burning

The pain is ◻ Constant ◻ Comes and goes (Intermittent). **Does your pain wake you from sleep?** ◻ Yes ◻ No Do you have? ◻ Swelling ◻ Bruise ◻ Numbness ◻ Tingling ◻ Weakness ◻ Loss of control of bowel or bladder

Since my problem started, it is: ◻ Getting better ◻ Getting worse ◻ Unchanged

What makes your symptoms **worse**? ◻ Standing ◻ Walking ◻ Lifting ◻ Exercise ◻ Twisting ◻ Lying in bed

◻ Bending ◻ Squatting ◻ Kneeling ◻ Stairs ◻ Sitting ◻ Coughing ◻ Sneezing

Which make your symptoms **better**? ◻ Rest ◻ Elevation ◻ Ice ◻ Heat ◻ Other ______________

What medications have you taken for this current problem? _

Are you in pain management? Y_____N______Pain management physician's name _______________

What tests/scans have you had for this problem? X-Rays____MRI____CAT scan_____EMG/NCS ___

Where were these tests done?_______

When is the last date you worked your regular job?_______________

Are you currently receiving or plan to apply for: Disability ◻ Y ◻ N Workman's Comp. ◻ Y ◻ N Unemployment ◻ Y ◻ N

Do you consider your health to be: Excellent Good Fair Poor

Do you exercise? Yes No What type of exercise?________________________________.

Consumption of caffeine-containing beverages (coffee, tea, cola):______# of cups per day.

Additional Information: (Please use this area to describe any history not discussed above)

____

____

____

Additional Concerns: ____

____

____

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I____certify that the above information is correct to the best of my knowledge. I will not hold the provider or members of the staff responsible for any errors or omissions that I have made in the completion of this form.

_______________________________________ _______________________________________

Patient Name/Legal Guardian Date

_______________________________________ _______________________________________

Reviewed By Date