

TELL US ABOUT YOU (Please print clearly)

Name:				Date:			
Date of Birth:		Age:	Sex: M F	Marital Status MS DW		# of children:	
Address:							
City:				Province:		Postal code:	
Home Phone #:				Cell #:			
E-mail Address:							
Spouse's Name:							
Occupation (Current or Previous)						Retired: Y N	
Current or Previous Work		Clerical: Y N	Light Labor: Y N	Moderate Labor: Y N		Heavy Labor: Y N	
In Case of Emergency Contact				Phone #			

TELL US ABOUT YOUR PAST HEALTH:

Y	N	Lower Back Pain	Y	N	Diabetes (A1C = _____)	Y	N	High Cholesterol
Y	N	Leg or Foot Pain/Numbness	Y	N	Hand Problems	Y	N	Shingles
Y	N	Prior Spinal Surgeries	Y	N	Neuropathy	Y	N	Cancer – Chemotherapy
Y	N	Spinal Fractures	Y	N	Heart Attack	Y	N	Kidney issues or Dialysis
Y	N	Spinal Stenosis	Y	N	Heart Problems	Y	N	Gout
Y	N	Spinal Arthritis	Y	N	High / Low Blood Pressure	Y	N	Knee / Hip / Foot Surgery
Y	N	Sciatica	Y	N	Vascular Leg Problems	Y	N	Leg Fractures
Y	N	Neck Pain	Y	N	Vascular Surgery	Y	N	Joint Replacement
Y	N	Herniated Disc	Y	N	Stroke	Y	N	Plantar Fasciitis

TELL US ABOUT ANY MEDICATIONS YOUR CURRENTLY ARE TAKING OR HAVE PREVIOUSLY TAKEN:

Y	N	LIPITOR (Atorvastatin)	Y	N	ZETIA (Ezetimibe)	Y	N	CYMBALTA (Duloxetine)
Y	N	CRESTOR (Rosuvastatin)	Y	N	HYDROCHLOROTHIAZIDE	Y	N	ELAVIL (Amitriptyline)
Y	N	ZOCOR (Simvastatin)	Y	N	BLOOD PRESSURE MEDS	Y	N	EFFEXOR (Venlafaxine)
Y	N	ALTOCOR (Lovastatin)	Y	N	LYRICA (Pregabalin)	Y	N	OXYCONTIN (Oxycodone)
Y	N	MEVACOR (Lovastatin)	Y	N	NEURONTIN (Gabapentin)	Y	N	LIDODERM PATCH
Y	N	LESCOL (Fluvastatin)	Y	N	TRILEPTAL (Oxocarbazine)	Y	N	CAPSAICIN (Zostrix)
Y	N	PRAVACHOL (Atorvastatin)	Y	N	TOPAMAX (Topiramate)	Y	N	OVER THE COUNTER MEDS

PLEASE LIST ANY **OTHER MEDICATIONS** YOU ARE CURRENTLY TAKING, BUT ARE NOT LISTED ABOVE:

PLEASE LIST ANY **VITAMINS** YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY **SERIOUS MEDICAL CONDITIONS** YOU HAVE HAD:

NAME OF YOUR **PRIMARY CARE PHYSICIAN**:

PLEASE LIST BELOW ANY **BACK OR LEG SURGERIES** YOU'VE HAD:

HAVE YOU HAD AN **EMG** PERFORMED ON YOUR LEGS/FEET? NO YES – WHEN?

DO YOU EXERCISE REGULAR? NO YES – WHAT?

WHAT KIND OF PROBLEM(S) ARE YOU HAVING:							
ON A SCALE, HOW WOULD YOU RATE YOUR SYMPTOMS (10 is the worst) 1 2 3 4 5 6 7 8 9 10							
WHEN DID THIS BEGIN:							
WHAT MAKES IT BETTER:							
WHAT MAKES IT WORSE:							
ARE YOUR SYMPTOMS WORSE AT NIGHT? NO YES					IF YES, AROUND WHAT TIME?		
HOW WOULD YOU DESCRIBE YOUR SYMPTOMS (Circle any that apply)	Stabbing-Sharp	Electric Shocks	Cold	Tingling	Pins & Needles	Dead Feeling	Throbbing
	Burning	Stings	Ache	Numbness	Swelling	Tiredness	Cramping
WHAT DO <u>YOU THINK</u> IS CAUSING YOUR PROBLEM:							
IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING: (Circle any that apply)							
WORK	SLEEP	DAILY ROUTINE	CHORES	WALKING	STANDING	SHOPPING	
REASON FOR THIS VISIT:							

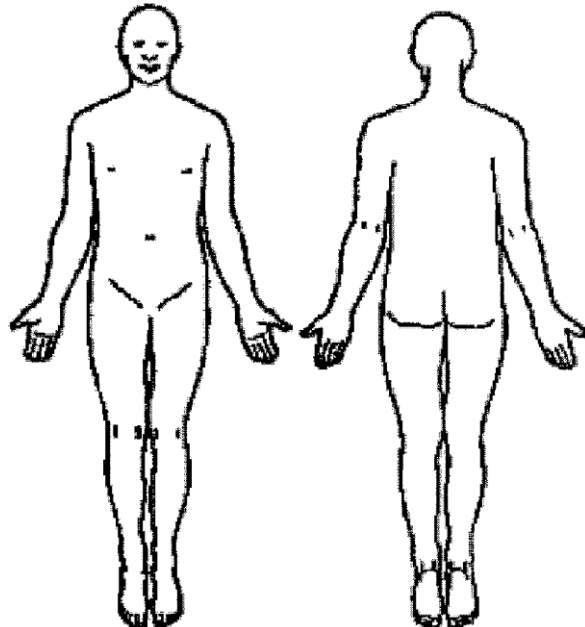
How would you describe your average back/leg pain over the past week?

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

Please indicate what you consider to be an acceptable level of pain after completion of the treatment if you have to accept some pain?

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

Please indicate on these drawings, the body area(s) where you are currently experiencing symptoms:



TELL US ABOUT HOW THIS IS AFFECTING YOU:

What are your symptoms like at their worst :			
Is your balance or walking ability starting to be affected? N Y if yes, describe how and in what ways			
Which of the following is true for your condition: (check one of the following)			
<table border="1"> <tr> <td>It's getting better on it's own</td> <td>It's staying the same</td> <td>It's getting worst as time goes by</td> </tr> </table>	It's getting better on it's own	It's staying the same	It's getting worst as time goes by
It's getting better on it's own	It's staying the same	It's getting worst as time goes by	
List any daytime activities (and used to be able to do when you were feeling better) that are now limited:			
List any "day-to-day" activities (OK to do now) that are getting harder and harder to do:			

- A. I hereby authorize release of any medical information' necessary to evaluate my case or process any future claims.

- B. I understand and agree that health policies are an arrangement between an insurance carrier and myself Therefore I understand that all future services are charged directly to me and agree to be personally responsible for payment

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?