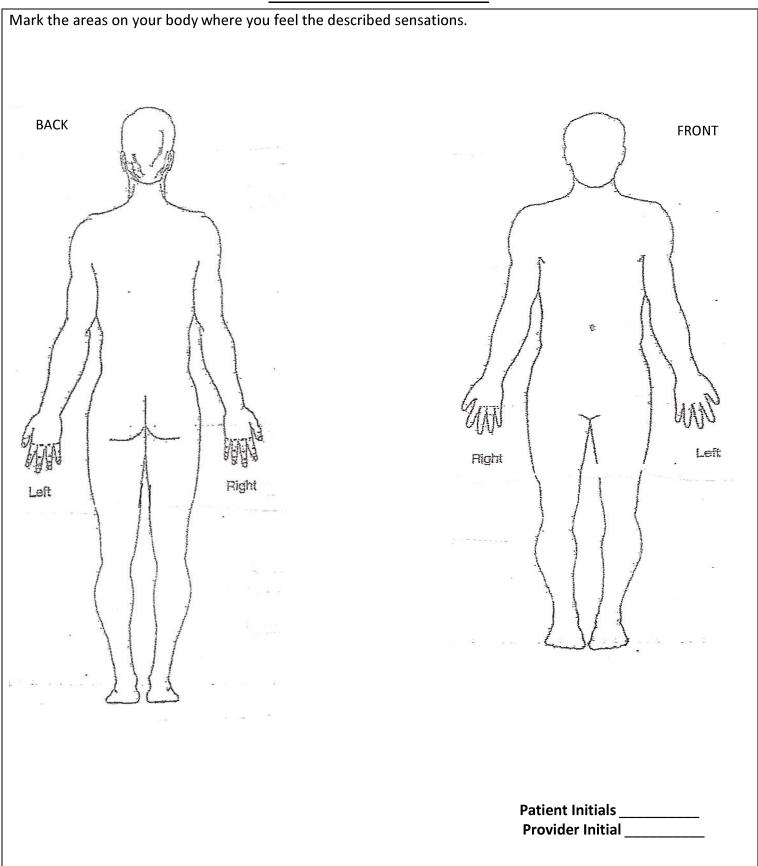
Date: COMPREHENSIVE SPINE CENTER

Dato.					
	Age: DOB:/				
Last Occupation: Hand Dominance: RT LT REASON FOR VISIT:	First Work Related Injury Motor Vehicle Accident Slip and Fall Date of Injury:/				
Seat Belt Air Bag Hea ER Visit: <u>YES</u> <u>NO</u> When:	nd Injury LOC Transported How:				
•	ere:				
F R O N T	Chiro. Treatment / PT: Times a week B				
CIRCLE IF ANY APPLY:	Missed work due to accident: Yes No How many days:				
HeadachesFRTBKRTLTNeck PainRTCNTLTLow Back PainRTCNTLTShoulder PainRTLTHip PainRTLT	Pain specialist: Y N Ortho Specialist: Y N Procedure types:				
Other 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_ (<i>Physician/PA Use Only</i>)	GLUCOSE Plan: 1.) 2.) 3.) 4.) 5.)				
	Patient Initials Provider Initial				

COMPREHENSIVE SPINE CENTER PATIENT PAIN DRAWING



COMPREHENSIVE SPINE CENTER PATIENT HISTORY

ALLERGIES				
MEDICATION ALLERGIES	1.	2.		
OTHER ALLERGIES	1.	2		
MEDICATIONS				
		tions and dosages inc	luding over the counter medication, h	erbal
Supplemer	nts and inhalers.			
List Pain Medicatio	ns/Dose 1		2	
	3		4	
List Other Medicati	ons 1		2	
List Stiller Medicati				
	3		4	
	5		6	
	7.		8	
PAST SURGICAL H			erv)	
Neck Surgery/		lacement//		
Back Surgery/	/ Appended	ctomy/	Cataracts//	
Tonsillectomy//	/ Cardiac So	ent/_	/	
Cardiac Bypass/	_/ Hysterect	omy//_	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	ТВ
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										
If yes, explain: Has a blood relative ever had and adverse reaction/problem with anesthesia?	Da	te of Last Anest	hetic/_							
Has a blood relative ever had and adverse reaction/problem with anesthesia?	На	ve you ever had	an adverse reaction	on problem with anes	thesia	a? □Yes	□No			
Stroke Bleeding Disorder Alcoholism Pleast Troubles Bleeding Disorder Alcoholism Pleast Troubles Bleeding Disorder Alcoholism Pleast Troubles Blood Diabetes Diabetes Blood Diabetes Diabetes Diabetes Blood Diabetes Diabete	If y	es, explain:								
Stroke Bleeding Disorder Alcoholism Heart Troubles Depression Cancer Hypertension Arthritis Blood Disobetes Mental Illness Other	На	s a blood relativ	e ever had and adv	verse reaction/proble	em wit	th anesthesia	a? □Yes		10	
Stroke Bleeding Disorder Alcoholism Heart Troubles Depression Cancer Hypertension Arthritis Blood Disobetes Mental Illness Other	Fai	mily History (C	Circle and indicate	whether Mother Or	Fathe	r)				
Hypertension		roke					Alcoholism			
Diabetes	_									
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 SKIN AND BREAT Change in Vision Rash Blurring Vision Ulcers Masses EARS/NOSE/THROAT ENDOCRINE Hearing Loss Diabetes Hoarseness Hypertension Vertigo Night Sweats Vertigo Night Sweats CARDIOVASCULAR NEUROLOGIC Chest Pain Hand Trembling Palpitations Memory Loss Abnormal Heartbeat Headaches Swollen Ankles Gait Disturbances RESPIRATORY PSYCH. Short of Breath Depression GI OTHER Hemorrhoids Diarrhea CORD Diarrhea Constipation Under Abdominal Pain										
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Constipation Abdominal Pain										
Abdominal Pain										
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Patient	Initials _	
Provide	r Initial	

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