BARRACK SPINE AND JOINT MEDICINE
1230 Johnson Ferry Place #H20, Marietta, GA 30068 Phone: 678-738-7601 Fax: 678-266-6176

NEW PATIENT HISTORY Date of Appointment_____/_____/_____

Last Name _____First Name _____Ml_____DOB _____Age _____ M/F___

Height _____Weight_____ Right-Handed Left- Handed

Mobile Phone number_____ Email: _____

Pharmacy Name _____ Pharmacy PH #_____

Referring Provider Name_____ PH#_____FAX#_____

Providers you would like information shared Name _____PH# _____FAX#_____

Date of Onset and Reason for Today's Visit

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1. What is your pain/symptom level on average: (0-10) O-No pain 10-Worst pain imaginable?
   1 2 3 4 5 6 7 8 9 10
2. Is the problem ___constant or ___comes and goes
3. Describe your pain __Sharp/ ___Dull/ __Stabbing/ __Achy/ __Tingling __Numbness __Throbbing __Burning __Stiffness
4. Does the pain go down the Arm(s)? __Yes ___No __RT __LT // or Leg(s)? __Yes ___No __RT __LT
5. Pain is Better (B) Worse (W) Sit- B/W Stand- B/W Walk- B/W Bend- B/W Lift - B/W

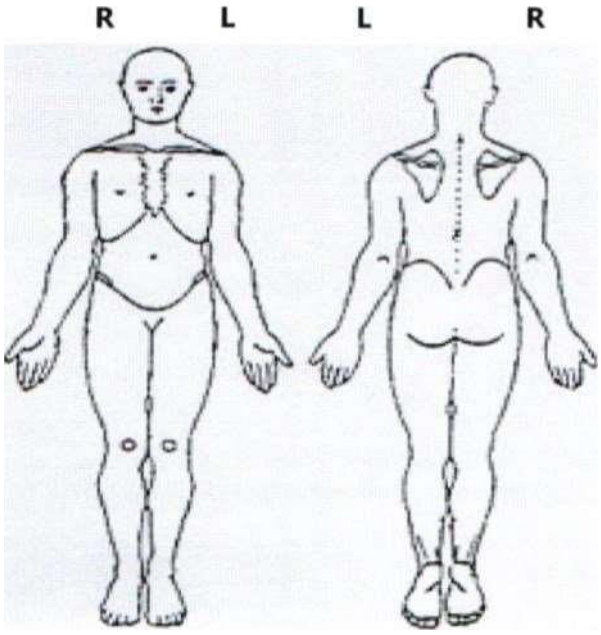
   Cough/Sneeze- B/W Lie/Recline- B/W AM- B/W PM- B/W
6. Does this issue inhibit or bother your sleep? __ Yes __No If yes, explain_____
7. Has this problem caused a change in bowel or bladder? ___Yes __No If yes, explain_____

Do you have imaging or testing related to this issue to review? ___Yes (please provide) ___No

List treatment for this issue /dates of treatments in last 3 years

1. Physical Therapy DATE_____ Beneficial Yes/No
2. Chiropractic DATE_____ Yes/No
3. Spinal Injections DATE_____ Beneficial Yes/No
4. Medications failed

Pain Drawing - Mark these drawings according to where you hurt -



Review of Systems: Please check the following

	Yes	No		Yes	No		Yes	No
Anxiety			Poor Hearing			Chest pain/palpitations		
Depression			Hearing Aids			Sleep Apnea/CPAP		
Fatigue			Abdominal Pain			Shortness of breath		
Insomnia			Constipation			Coughing/Wheezing		
Headaches			Diarrhea			Nausea/vomiting		
Migraines			Nausea/Vomiting			Swollen glands		
Memory Loss			Incontinence			Neck Pain		
Tremors			Urinating at Night			Arm/Leg Pain		
Joint Pain/Swelling			Abnormal Weight Change			Cold or Numb Extremity		
Leg swelling			Gynecological Issues			Bleeding/Bruising		
Fever/Chills			Night Pain			Skin Wounds/rashes		

Medication Allergies: Please List _____

Current Medications —. Include herbal and over the counter drugs. Use additional sheet if needed.

Drug	Dose	Frequency	Condition

Past Medical History:

__Acid reflux/Ulcers
__Irritable/Inflammatory Bowel DS
__Alzheimer's/Dementia
__Osteoarthritis Hips/Knees
__Epilepsy/ Seizures
__ Coronary artery disease
__ Lung Disease
__Atrial fibrillation or Pacemaker
__ Thyroid Disease
__Cancer/Type
__Rheumatoid Arthritis
__Depression
__Diabetes Type I/II
__Mental Health D.O.
__ High Blood pressure
__ Vascular disease
__Fibromyalgia
__Gout
___Other Autoimmune D.O
__Hepatitis A/B/C
__Blood Clot leg(s)/lungs
__HIV
__ kidney disease
__EDS/Hypermobility
__Blood Disorders
__Stroke
__Hyperlipidemia/cholesterol
___Other

Surgical History:

Please check below if you have had any of these surgeries:

__Cervical Spine surgery
__Bone or Joint Replacement
__angioplasty/ Stents
__gastric bypass surgery
__Other _____
__Lumbar Spine surgery
__Pacemaker/Defibrillator
__Hysterectomy (Partial or total)
__Heart Surgery

Family History:

Family Member	Diagnosis
(i.e. Mother/Father)	

Social History: Smoking: ___Never smoke __Former smoker __Current smoker/ How many packs a day?_____

Marital Status: ___Single ___Married ___Partner ___Divorced ___Widow/Widower ___Pets

Occupation: _____ __retired __part time __fulltime __disabled

Do you drink alcoholic beverages? __Yes __No If Yes, how frequent? _____

History of recreational drug or alcohol abuse? __Yes __No If Yes, explain_____