Medicus SPINE & JOINT

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Patient Demographic Information

Name _____ Date of Birth _____ Sex M F

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

SSN _____ Email Address _____

Occupation _____ Employer _____ Primary Language _____

Spouse/Significant Other Name _____ Phone _____

Emergency/HIPAA Contact _____ Phone _____

Address _____ Phone _____

Incident/Injury Information

Is this injury work related? Yes No **Was this injury caused by a motor vehicle crash?** Yes No

Date of Auto Crash_____ Date of Incident /Injury _____

Auto Insurance _____ WC Insurance _____

Policy Number _____ WC Policy Number _____

Claim Number _____ WC Claim Number _____

Attorney Information

Firm Name _____ Phone _____

Case Manager _____ Phone _____

Attorney _____

Patient Name _____ Phone _____

Crash/Incident/Injury Details

Date of Injury: _____

Brief Description of the Crash/Fall/Incident: _____

_____

_____

If your injury is the result of a motor vehicle crash, were you:

Were you the: Driver Passenger **Were you wearing a seat belt?** Yes No

Did the airbags deploy? Yes No **Did you hit your head?** Yes No

Did you lose consciousness? Yes No

Were you taken to the emergency room? Yes No

If yes, where? _____ How did you get there? Ambulance Drove

If no, when was the first time you sought medical treatment? _____

Where? _____

COMPLAINTS

Please mark the areas where you feel pain and/or discomfort. **1=mild** **10=severe**

ALSO, please rate the pain in each area from 1-10:

_____ Headaches/Dizziness _____Elbow (Left or Right) _____Knee Pain (Left or Right)

_____Memory/Mood Changes _____ Wrist (Left or Right) _____ Ankle Pain (Left or Right)

_____Neck Pain _____ Hand Pain(Left or Right) _____ Foot Pain(Left or Right)

_____ Upper/Mid Back Pain _____Low back Pain _____ Other Pain

_____ Shoulder (Left or Right) _____ Hip Pain(Left or Right)

Other Symptoms/Issues since the injury: _____

_____

Please describe the type of pain you are having (Circle all that apply)

Sharp Aching Shooting Burning Cramping Throbbing Stabbing Itchy

Sore Dull Tight Stinging Mild Stiffness Moderate Stiffness Severe Stiffness

How often do you have this pain? (Circle all that apply)

Constant Intermittent Daily Every few days Weekly or less Monthly or less

What makes the pain worse? (Circle all that apply)

Activity Bending Running Reaching Lying down/sleeping Prolonged Walking

Prolonged Sitting Prolonged Standing Changing Positions Lifting Weight Twisting/Rotation

Patient Name _____ Phone _____

What makes the pain better? (Circle all that apply)

Nothing Rest Movement Heat Therapy Elevation

Medication Changing Positions Other _____

Are you taking any medications for the pain? Yes No If yes, does the medication help? Yes No

If yes, please list the medication, strength/dosing: _____

_____

Have you had any bowel/bladder changes such as wetting your pants or soiling yourself since this injury? Yes No

Do you have increased pain from coughing or sneezing Yes No

Do you have any radiating pain? (Pain that shoots from one area to another) Yes No

If yes, please describe: _____

Do you have any tingling, pins and needles or burning sensations? Yes No

If yes, please describe: _____

Do you have any feelings of muscle weakness? Yes No

If yes, please describe: _____

Since the onset of your pain, is it: Better Unchanged Worse

Treatment Details

Are you currently attending or completed therapy? Yes No If yes, where?

_____ **What type of therapy?** (Circle all that apply)

Chiropractic Physical Therapy Occupational Therapy Massage Therapy

Acupuncture Modalities (Ultrasound, Electrical Stimulation, Hot/Cold Packs)

Has the therapy helped? Yes No

If you are not currently having therapy, have you had therapy for this problem before? Yes No

If so, where and when? _____

Have you had any type of injections for this problem? Yes No

If so, what type of injections did you have? (Circle all that apply) **Did the injections help?** Yes No

Epidural Injections Trigger Point Injections; Location: _____

Facet Injections Other: _____

Patient Name _____ Phone _____

Medical Information

MEDICAL HISTORY (Please circle all that apply)

Hypothyroidism	Anxiety	Hypertension	Asthma
Hyperthyroidism	Insomnia	Ischemic Heart Disease	COPD
Diabetes II	Depression	Atrial fibrillation	GERD
Diabetes I	Epilepsy	Congestive Heart Failure	Fibromyalgia/ Myositis
High Cholesterol	Migraine	Stroke/TIA	Kidney Disease
Alzheimers	Parkinsons	HIV/AIDS	Cancer _____
Sleep Apnea	Rheumatoid Arthritis	Osteoporosis	

Other: _____

SURGICAL HISTORY:

Date: _____ Surgery : _____ Complication: _____

Date: _____ Surgery : _____ Complication: _____

Date: _____ Surgery : _____ Complication: _____

PHYSICIAN INFORMATION:

Primary Care Physician _____

Other Providers/Specialists _____

_____

ALLERGIES:

None: Please check if no known allergies

	Allergy	Reaction
1		
2		
3		
4		
5		

Are you allergic to LATEX? Yes No

If Yes, What is your reaction? _____

Patient Name _____ Phone _____

MEDICATIONS

	Medication	Strength	Pills per day
1			
2			
3			
4			
5			
6			
7			
8			

Pharmacy Name _____

Pharmacy Address _____

REVIEW OF SYSTEMS

SINCE THE ACCIDENT, HAVE YOU HAD PROBLEMS WITH: (IF YES, PLEASE DESCRIBE)

SKIN?	YES	NO
EAR, NOSE, THROAT?	YES	NO
CARDIAC, HIGH BLOOD PRESSURE?	YES	NO
LUNGS, ASTHMA, INFECTION?	YES	NO
STOMACH, DIGESTION?	YES	NO
BLADDER/BOWEL PROBLEMS?	YES	NO
HEMATOLOGIST/BLEEDING PROBLEMS?	YES	NO
DIABETES?	YES	NO
CANCER?	YES	NO
MUSCULOSKELETAL?	YES	NO
NEUROLOGICAL?	YES	NO
PSYCHIATRIC PROBLEMS?	YES	NO
REPRODUCTIVE/SEXUAL PROBLEMS?	YES	NO
FEVER/CHILLS?	YES	NO
NIGHT SWEATS?	YES	NO
NIGHT PAIN?	YES	NO
UNEXPECTED WEIGHT LOSS?	YES	NO

Patient Name _____ Phone _____

Patient History

Social History:

AGE: _____OCCUPATION: _____

Marital Status:

Single Married Divorced Widowed

Work Status:

Full Time Part Time Disabled Retired Unemployed

Exercise:

Daily Weekly Monthly Rarely Never

Children: No Yes **If So, How many?** _____

Do you live alone? No Yes

How many floors in your home? _____

Do you smoke? No Yes

If Yes, How many packs per day? _____ **How many years?** _____

Other Nicotine Products? No Yes If Yes, Which _____

Drink Alcohol?

Never 1-2 Week 1-2 Month 1-2 Year Daily

Family History: (If Yes, Please specify which family member on line provided)

ARTHRITIS?	YES	NO	_____
BLOOD CLOTS/EXCESSIVE BLEEDING?	YES	NO	_____
HYPERTENSION?	YES	NO	_____
DIABETES?	YES	NO	_____
CANCER?	YES	NO	_____
ADVERSE REACTION TO ANESTHESIA?	YES	NO	_____
MENTAL HEALTH DISORDERS?	YES	NO	_____
CARDIAC DISORDERS?	YES	NO	_____
HIGH CHOSLESTERAL?	YES	NO	_____

Patient Name:_____ Date:_____

Please make the location of your pain using the symbols below:

///// : Ache xxxx : Pain oooo : Tingling - - - - : Numb