Buckhead Injury Wellness Institute

Patient Name:

Referring Physician:

Is your problem: ❑ Work related ❑ Auto or Other Accident related ❑ Neither

Do you have legal representation? ❑ Yes ❑ No

Are you being covered under Work Comp ❑ Yes ❑ No

Please briefly describe your **MAIN** problem/ complaint:

How long have you had this problem:

Did your problem start suddenly or gradually with time?

Are there any events, such as injuries, falls, illnesses, etc. that coincide with the date the problem started? If yes explain:

Character of pain (check as many that apply): Sharp ❑ Dull/Ache ❑ Numb ❑ Burn ❑ Stabbing ❑ Throb ❑ Pins/Needles ❑ Other ❑

Indicate here the usual degree of you pain:

Least ❑0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 the worst

Please indicate in detail where the location of any of the following symptoms, numbness, aching, pain, pin and needles sensation:

Radiation: does the pain radiate beyond where the pain starts? ❑Yes (Where?) ❑ No

What position(s) or activities make the pain worse?

❑ sitting ❑ standing ❑ walking ❑ bending ❑ lying down ❑ other:

What position(s) or activities make the pain better?

❑ sitting ❑ standing ❑ walking ❑ bending ❑ lying down ❑ other:

Do you need support to help you walk – if yes what kind (example: cane, walker)?

Do you wear a back or neck or any kind of limb brace? If yes for how long (explain in detail):

PLEASE LIST BELOW ANY DOCTORS, CHIROPRACTORS, ACUPUNCTURISTS, ETC. YOU HAVE SEEN OR TREATED BY FOR THE PROBLEM PRESENTING TODAY (USE THE BACK OF THE SHEET IF NECESSARY)

Physician	Specialty	Date of last visit	Treatment

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For your main problem you are presenting here today, please indicate which diagnostic tests you have had to evaluate this problem					
Exam	When & Where	Exam	When & Where	Exam	When & Where
Plain X-ray		CT Scan		MRI	
Bone Scan		Arthrogram		Sleep Study	
Myelogram		EMG/NCV/SSEP		Other	

Treatment	**Did it/they help**	# of Sessions/type of procedure
❑ Chiropractic Care/Manipulations	❑ Yes ❑ No	
❑ Physical Therapy	❑ Yes ❑ No	
❑ Home Exercise Program	❑ Yes ❑ No	
❑ Electrical Stimulation/TENS	❑ Yes ❑ No	
❑ Hot/Cold Packs	❑ Yes ❑ No	
❑ Ultrasound	❑ Yes ❑ No	
❑ Massage	❑ Yes ❑ No	
❑ Aquatics/Whirlpool	❑ Yes ❑ No	
❑ Acupuncture	❑ Yes ❑ No	
❑ Injections: Joint/Epidural	❑ Yes ❑ No	
❑ Implantable Pumps	❑ Yes ❑ No	
❑ Other	❑ Yes ❑ No	

MEDICATIONS: Please indicate all current **medications** with **dosages** and **frequency**:		

Please indicate all **previous medications** prescribed in the past with **maximum dosages** and **frequency** tried:		

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ALLERGIES: List all medication you have taken that caused side effects/allergic reaction – **ALSO LIST WHAT HAPPENS WHEN TAKE THE MED**:

Allergy	**Reaction**	**Allergy**	**Reaction**
X-ray Contrast ❑ Yes ❑ No		Other ❑ Yes ❑ No	
Iodine/Betadine ❑ Yes ❑ No			
Shellfish ❑ Yes ❑ No			

Past Medical and Surgical History: (List all problems/surgeries, not just the problem(s) you are here for)

❑ Diabetes	❑ High Blood Pressure	❑ High Cholesterol
❑ Stroke		

Social History

Occupation:

Full Duty ❑	Light Duty ❑	Unemployed ❑	Retired ❑	Disability ❑ Reason: Permanent ❑ Temporary ❑

Tobacco use	❑ Current ❑ Never ❑ Quit	Packs per day:	Age started: Age stopped:
Alcohol use	❑ Current ❑ Never ❑ Quit	How Much per day: What type:	Age started: Age stopped:
Drug Use	❑ Current ❑ Never ❑ Quit	What type: ❑ Marijuana ❑ Cocaine ❑ Heroin ❑ Methamphetamine ❑ Other:	Age started: Age stopped:

Have you ever been treated for substance:			When:
Dependency	❑ Yes	❑ No	
Abuse	❑ Yes	❑ No	
Addiction	❑ Yes	❑ No	

Family History: Describe current health, cause of death or illness of theses family members

Father:

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Mother:
Siblings:

Review of Systems: Do you have any of the following problems?					
	YES	NO		YES	NO
General Symptoms:			**Cardiac**		
Fatigue			Heart Failure/Cardiovascular Disease		
Weight Loss			Chest Pain		
Fever, Chills			Palpitations		
Night Sweats			Pace Maker		
Loss of Appetite			Heart Attack		
Other			High Blood Pressure (Hypertension)		
			Pace Maker		
Neurological/HEENT:			Other		
Bowel/Bladder Dysfunction					
Headaches			**Respiratory:**		
Blurry or Double Vision			Shortness of Breath		
Dizziness			Frequent Cough		
Passing Out (Syncope)			Wheezing		
Hearing Loss			Lung Disease		
Weakness			Tuberculosis		
Difficulty Speaking or Walking			Coughing Blood		
Problems Swallowing			Pneumonia		
Strokes			Emphysema		
Seizures			Asthma		
Other			Other		
Psychiatric:			**Gastrointestinal:**		
Depression			Incontinence		
Insomnia			Nausea or Vomiting		
Anxiety			Mouth Sores		
Psychiatric Illness			Abdominal Pain		
Other			Constipation		
			Diarrhea		
			Ulcers		
Genitourinary			Bloody Bowel Movements		
Incontinence			Liver Disease/Problems		
Prostate Disorder			Gall Bladder Disease		
Blood in Urine			Other		
Difficulty or Pain on Urination					
Kidney Disease					
Other			**Hematologic/Lymphatic:**		
			Bruising		
Musculoskeletal:			Bleeding Problems		
Swelling Feet/Legs			Low Blood Cant		
Pain/Swelling Joints			Swollen Glands		
Back Pain			Lymph Nodes (Lumps or Bumps)		
Rheumatoid Arthritis			Blood Clots		
Osteoarthritis			Other		

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Other					
			GYN:		
Skin/Integumentary:			**Are you pregnant or is there any chance**		
Rash			**that you could be pregnant?**		
Ulcers			Vaginal Bleeding		
Skin Disorders			Other		
Other					
Endocrine:					
Thyroid Disease/problems					
Diabetes					
Other					

The preceding patient information has been reviewed and discussed with my patient.	
Signature of patient or person completing the form	Physician's signature