PATIENT INFORMATION

First Name: _____ Middle _____

Last Name: _____ Title _____

Address: _____

Zip Code: _____ City: _____ State : _____

Home Phone: _____ Cell Phone #: _____

Office Phone: _____ Contact #: _____

SSN #: _____ Date of Birth: _____ Month _____ Day _____ Year

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Significant Other ☐ Separated ☐ Divorced ☐ Widowed

Insurance: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self Pay ☐ Worker's Comp ☐ MVA ☐ Personal Injury

Referred By: ☐ Physician _____ ☐ Self ☐ OR _____

Have you seen Dr. Kohrman before? ☐ Yes ☐ No ☐ When ? _____

Family Physician: _____ Where : _____

Employer: _____ Employed how long? _____

Address: _____

Zip Code: _____ City: _____ State : _____

Primary Insurance: ☐ **Commercial** ☐ **Medicare** ☐ **Medicaid** ☐ **Self Pay** ☐ **Worker's Comp** ☐ **MVA**

Carrier Name: _____ Effective Date: _____ Month _____ Day _____ Yr

Employer: _____ Contact #: _____

Subscriber's Last Name: _____ First Name: _____ Middle Initial: _____

Relationship: ☐ Self ☐ Spouse Subscriber's Date of Birth _____ Month _____ Day _____ Yr

Address: _____

Zip Code: _____ City: _____ State : _____

Home Phone: _____ Cell Phone #: _____

Office Phone: _____ Contact #: _____

Subscriber's SSN #: _____ Subscriber's Sex ☐ Male ☐ Female

Secondary Insurance: ☐ **Commercial** ☐ **Medicare** ☐ **Medicaid** ☐ **Self Pay** ☐ **Worker's Comp** ☐ **MVA**

Carrier Name: _____ Effective Date: _____ Month _____ Day _____ Yr

Employer: _____ Contact #: _____

Subscriber's Last Name: _____ First Name: _____ Middle Initial: _____

Relationship: ☐ Self ☐ Spouse Subscriber's Date of Birth _____ Month _____ Day _____ Yr

Address: _____

Zip Code: _____ City: _____ State : _____

Home Phone: _____ Cell Phone #: _____

Office Phone: _____ Contact #: _____

Subscriber's SSN #: _____ Subscriber's Sex ☐ Male ☐ Female

WHAT PHARMACY DO YOU GO TO?

Name: _____

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Phone #: ☐☐☐ ☐☐☐ ☐☐☐☐ Fax #: ☐☐☐ ☐☐☐ ☐☐☐☐

WHAT MAIL-IN PHARMACY DO YOU GO USE? Do they have a 90 day supply? ☐ Yes ☐ No ☐ Maybe

Name: _____

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Phone #: ☐☐☐ ☐☐☐ ☐☐☐☐ Fax #: ☐☐☐ ☐☐☐ ☐☐☐☐

AUTHORIZATION & ASSIGNMENT

Unless you have provided insurance information, you are responsible for payment of services when rendered.
Patients who carry Medical / Surgical Insurance should remember that Professional Services (Physician's Fees) are charges to You (or the patient) and not to the Insurance Company. Each Insurance Company has it's own policy or policies concerning payment of services. Some pay fixed allowances for certain procedures and others pay a percentage of the charge. There are no standard Usual Customary and Reasonable (UCR) charges that all of the Insurance Companies follow. It is your responsibility to know what your policy covers. *It is your responsibility to pay any deductible amount, co-pay amount, or any other balance not paid for by your Insurance Policy / Company.*

If this amount is assigned to a Collection Agency and / or it's Attorney for collection and / or suit, Southern Pain and Rehab, LLC / Dr. Kohrman shall be entitled to reasonable fees and the cost of collection. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as the original.

ALL PATIENTS (COMMERCIAL INSURANCE, MEDICAID, MEDIGAP, WORKER'S COMP, MVA)
I request that payment of authorized Insurance Benefits be made either to me or on by behalf to Southern Pain and Rehab, LLC / Dr. Kohrman for any services furnished to me by that physician. I authorize release to my Insurance Company and it's agents any medical information about me needed to determine the payments for related services.

I understand that I will be charged a ***$25.00 No Show Fee,*** if I miss an appointment, that needs to be paid before I can be see again. I understand that this office ***requires a two (2) day notice if I need to reschedule or cancel a scheduled Office Visit***.

Signature: _____ **Date** ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

PUT YOUR APPOINTMENT DATE HERE

First Name: _____ **Last Name:** _____

MEDICARE PATIENTS ONLY
I request that payment of authorized Medicare Benefits be made either to me or on by behalf to Southern Pain and Rehab, LLC / Dr. Kohrman for any services furnished to me by that physician. I authorize release to the Centers for Medicare and Medicaid Services and it's agents any medical information about me needed to determine the payments for related services.

Signature: _____ **Date** ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

PUT YOUR APPOINTMENT DATE HERE

First Name: _____ **Last Name:** _____

AKNOWLEDGEMENT OF NOTICE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Signature: _____ **Date** ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

PUT YOUR APPOINTMENT DATE HERE

First Name: _____ **Last Name:** _____

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Hours by Appointment

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Name _____ **Claim #** _____ **Date** _____

DOB _____ **SSN XXX-XX-** _____ ☐ **Initial Evaluation** ☐ **Follow Up**

Age ☐☐☐ ***Race*** _____ ☐ ***Male*** ☐ ***Female*** ☐ ***Transgender*** ☐ RT ☐ Lft ***Handed***

This problem is ☐ Work Related ☐ Personal Injury ☐ Motor Vehicle Accident *An Attorney is working on this case* ☐ No ☐ Yes

Onset Date ☐ *On* ☐ *Somewhere around* *Day* ☐☐ *Month* ☐☐ *Year* ☐☐☐☐ *Onset was* ☐ Sudden ☐ Gradual

How are you doing ☐ Functional ☐ Dysfunctional ☐ Better ☐ NML ☐ Same ☐ MMI ☐ Worse ☐ Deteriorating ☐ Depressed/Suicidal

Work Status ☐ N/A ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled ☐ Working ☐ Part Time ☐ Restrictions _____

Main Complaint ☐ Pain ☐ Weakness ☐ Numbness ☐ Instability ☐ In-Coordination ☐ Confusion ☐ Balance ☐ Swelling ☐ Emotions

Or?

What's Happened?

What Helps?

What Aggravates it?

Recent Tests & Results?

Had Therapy? ☐ No ☐ Yes ☐ Helped ☐ Same ☐ Worse ***TENS Unit?*** ☐ No ☐ Yes ☐ Helped ☐ Same ☐ Worse

Manipulation ? ☐ No ☐ Yes ☐ Helped ☐ Same ☐ Worse ***Procedure-s ?*** ☐ No ☐ Yes ☐ Helped ☐ Same ☐ Worse

Recent Procedure-s

Recent Medical Changes ☐ No ☐ Yes _____

Recent Surgical Changes ☐ No ☐ Yes _____

Energy Level ☐ OK ☐ Chronic Fatigue ☐ Disturbed Sleep ☐ Snores ☐ Naps ☐ Sleep Apnea ***Uses*** ☐ CPAP ☐ BIPAP ☐ Oxygen

Sexual Concerns ☐ N/A ☐ No ☐ Yes ***Issues*** ☐ No Desire ☐ Physical ☐ Emotional ☐ Impotency ☐ Pain _____

Diet Change ☐ No ☐ Yes ***Diet*** _____ ***Allergy Changes*** _____

Pain Medications ☐ No ☐ Yes ☐ Helps ☐ Same ☐ Worse ***Side Effects*** _____

In the Past 3 Months Who Prescribed Pain Medications for you? _____

Still Using ☐ Tobacco ☐ Nicotine ☐ Caffeine ☐ Alcohol ☐ Illegal Drugs ☐ Others Meds ***Has History of*** ☐ Alcoholism ☐ Drug Abuse

ROS: Do you have any NEW problems with any of the following? ☐ No ☐ Yes ***Please Mark the NEW PROBLEMS that apply below***

☐ Fever /Chills ☐ Night sweats ☐ Infections ☐ Cold / Flu ☐ Weight Gain ☐ Weight Loss ☐ Bleeding ☐ Bruising ☐ Clotting
☐ Limb Swelling ☐ Head ☐ Eyes ☐ Ears ☐ Nose ☐ Mouth ☐ Neck / Throat ☐ Chest ☐ Ribs ☐ Abdomen ☐ Pelvis ☐ Groin
☐ Heart ☐ Lungs ☐ Esophagus ☐ Stomach ☐ GI Tract ☐ Liver ☐ Gallbladder ☐ Pancreases ☐ Intestines ☐ Colon ☐ Rectum
☐ Breasts ☐ Female Organs ☐ Male Organs ☐ Kidney ☐ Bladder ☐ Ureters ☐ Hormones ☐ Skin ☐ Nerves ☐ Muscles ☐ Bones
☐ Joints ☐ Tendons ☐ Ligaments ☐ Blood Vessels ☐ Blood Pressure ☐ Thinking /Memory ☐ Emotions ☐ Family ☐ Friends ☐ Work

What

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Name _____ **Claim #** _____ **Date** _____

DOB _____ **SSN XXX-XX-** _____ **INTAKE QUESTIONS**

Today's visit is for an? ☐ Initial Eval ☐ Follow Up ☐ IME ***Condition?*** ☐ MVA ☐ Work Related ☐ Personal Injury

Main Problem? _____ ***Sudden Onset*** ☐ Yes ☐ No ***Date Of Onset?*** _____

Who Sent You Here? ☐ Self ☐ PCP ☐ Specialist ☐ Surgeon ☐ Chiropractor ☐ Attorney ☐ Case Manager ☐ Other

☐ Primary Care Doctor _____ ☐ Neuro-Surgeon _____

☐ Specialist _____ ☐ Orthopedist _____

☐ Specialist _____ ☐ Spine Surgeon _____

☐ Specialist _____ ☐ Surgeon _____

☐ Chiropractor _____ ☐ Surgeon _____

☐ Attorney _____ ☐ Case Manager _____

Is Litigation Pending for this? ☐ Not Sure ☐ No ☐ Yes ***For What?*** _____

Previous law Suites? ☐ No ☐ Yes ***For What?*** _____

Where You in the Military? ☐ No ☐ Yes ***How Long?*** _____ ***Branch*** _____ ☐ Disabled ☐ Retired

Disabled for _____ ☐ ***How Long?*** _____

Current Work Status? ☐ Not Working ☐ Student ☐ Working Full Time ☐ Working Part Time ☐ Disabled ☐ Retired

☐ Self Employed _____ ☐ Works for? _____

☐ ***Job is?*** _____ ☐ ***Been Doing it How Long?*** _____

Has Restrictions _____ ☐ ***How Long?*** _____

Disabled for _____ ☐ ***How Long?*** _____

Your Job Classification is? ☐ Sedentary ☐ Light Duty ☐ Mild Duty ☐ Moderate Duty ☐ Heavy Duty ☐ Extreme Duty

Hazardous Conditions? ☐ No ☐ Yes ***What?*** _____ ***Required Max Lifting is?*** _____ Pounds

Lifting Pounds Required? ***Occasionally*** _____ Pounds ***Routinely*** _____ Pounds ***Rarely*** _____ Pounds

Any Old Injury? ☐ No ☐ Yes ***What?*** _____ ***When?*** _____

Old Injury? What? _____ ***When?*** _____

Old Injury? What? _____ ***When?*** _____

Old Injury? What? _____ ***When?*** _____

Old Injury? What? _____ ***When?*** _____

EDUCATION? How far have you gotten so far? Please Mark All that best describes you. ***Still in School?*** ☐ No ☐ Yes

☐ Grade School ☐ High School ☐ Associate's ☐ Master's ☐ Attorney ☐ DDS ☐ _____

☐ GED ☐ Trade School ☐ Bachelor's ☐ PHD ☐ Chiropractor ☐ Medical Doctor ☐ _____

What Sports Did You Play? _____

What Sports Do You Play? _____

What Hobbies Do You Have? _____

What Do You Want to Do? _____

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Name **Date**

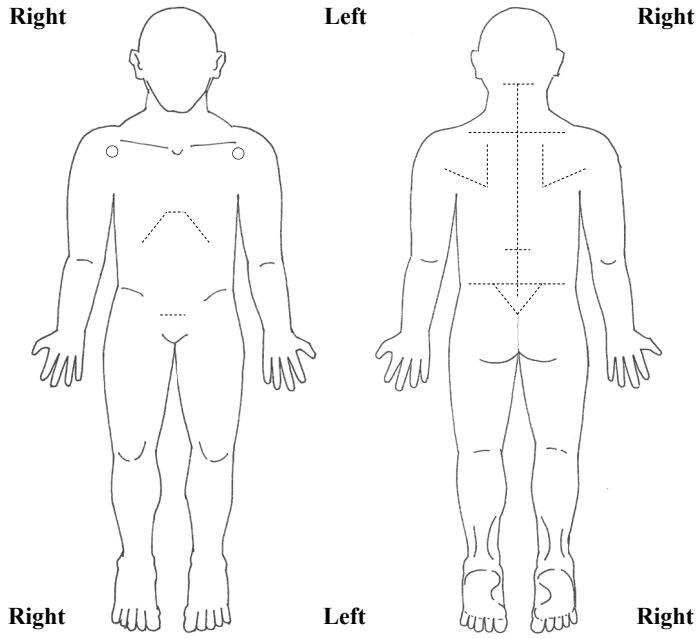
DOB **SSN** XXX-XX **INTAKE** ***Please fill in ALL that applies.***

Problems with	Pain Quality	Pain Quality	Pain Intensity	Pain Occurs	Pain Occurs	Duration	Your Sleep is
☐ Pain	☐ Throbbing	☐ Aching	☐ No Pain	☐ Rarely	☐ Morning	☐ Seconds	☐ OK to Good
☐ Numbness	☐ Shooting	☐ Tender	☐ Mild	☐ Occasional	☐ Lunchtime	☐ Minutes	☐ Poor to Bad
☐ Weakness	☐ Stabbing	☐ Splitting	☐ Moderate	☐ Sometimes	☐ Afternoon	☐ Hours	☐ Snores & Naps
☐ Thinking	☐ Sharp	☐ Exhausting	☐ Severe	☐ A lot	☐ Dinnertime	☐ All Day	☐ Falls Asleep
☐ Balance	☐ Cramping	☐ Sickening	☐ Distressing	☐ Always	☐ Evening	☐ All Night	**New Problems with**
☐ Coordination	☐ Gnawing	☐ Fearful	☐ Horrible	☐ Activity	☐ Nighttime	☐ Varies	☐ Bowel Control
☐ Joint-s	☐ Burning	☐ Punishing	☐ Excruciating	☐ With Rest	☐ Varies	☐ Always	☐ Bladder Control

WHERE IS YOUR PAIN NOW ?

Use the Symbols to Mark Where you have Pain on the Body below

Aching △△△ Numbness === Pins/Needles OOO Burning XXX Stabbing /// Other •••



CIRCLE the Face that Best Describes Your Overall Mood?

IF No Pain as " 0 " and the Worst Pain you ever had is "10"

What is Your Current Pain Level? _____

On A Good Day? _____ **On A Bad Day?** _____ **Overall?** _____

ARE YOU SUICIDAL ? ☐ No ☐ Yes

Your Primary Care Physician is

Do you have Localized Weakness? Mark Only if you have it.

What Side	Rt	Lft	What Side	Rt	Lft	What Side	Rt	Lft
Head/Neck	☐	☐	Arm	☐	☐	Leg	☐	☐
Trunk	☐	☐	Shoulder	☐	☐	Hip	☐	☐
Back	☐	☐	Elbow	☐	☐	Knee	☐	☐
Pelvis	☐	☐	Wrist-Hand	☐	☐	Ankle-Foot	☐	☐

Do you have any In-coordination Problems with the Following?

Head Spine Trunk		Upper Limbs		Lower Limbs	
☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
Rt Side	Left Side	Rt Side	Left Side	Rt Side	Left Side
☐	☐	☐	☐	☐	☐

Do you have Any Joint Problems? Mark Only if you have it.

Side?	Rt	Lft	Hand	Side?	Rt	Lft	Side?	Rt	Lft
TMJ	☐	☐	Digit # 1	Thumb	☐	☐	SI	☐	☐
Sternum	☐	☐	Digit # 2	Index	☐	☐	HIP	☐	☐
Shoulder	☐	☐	Digit # 3	Middle	☐	☐	Knee	☐	☐
Elbow	☐	☐	Digit # 4	Ring	☐	☐	Ankle	☐	☐
Wrist	☐	☐	Digit # 5	Little	☐	☐	Foot	☐	☐

In the past 6 months How Many People Wrote Pain Meds for you?

0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*More*
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Have you used any Anti-inflammatory medication? ☐ No ☐ Yes

Have you been in Physical-Occupational Therapy? ☐ No ☐ Yes

History of Physical, Emotional, or Sexual Abuse? ☐ No ☐ Yes

Any History of Mental or Emotional Issues? ☐ No ☐ Yes

Any History of Drug or Alcohol Abuse Problems? ☐ No ☐ Yes

Have you Had Problems Before with Any Doctor? ☐ No ☐ Yes

Have you Ever Failed a Drug Screen or Testing? ☐ No ☐ Yes

Have you Ever been Discharged from an Office? ☐ No ☐ Yes

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Name _____ **SSN XXX-XX-** _____ **DOB** _____ **Date** _____

From the group below what Descriptions BEST describes you and your current situation?

☐	☐	☐	☐	☐
Asymptomatic Or Intermittent Symptoms	Symptoms with Strenuous Activity Able to do Self-Care Independently	Symptoms with Normal Activity; Able to do Self-Care with Moderate Help but Unassisted	Symptoms with Less than Normal Activity Requires Some Help to do Self Care	Symptoms at Rest Not Able to do Self Care Needs Significant Help to do Self Care

Do you need anyone to help you? ☐ NO ☐ YES WHO ? _____

What do they do for you? _____

What AGGRAVATES your Overall Problem-s?

☐ Nothing	☐ Standing	☐ Bathing	☐ Working
☐ Rest	☐ Bending	☐ Shower	☐ Heat
☐ Sitting	☐ Twisting	☐ Dressing	☐ Cold
☐ Laying Down	☐ Reaching	☐ Dishes	☐ Therapy
☐ On Side	☐ Lifting	☐ Housework	☐ Massage
☐ On Back	☐ Climbing	☐ Driving	☐ Meds
☐ On Stomach	☐ Walking	☐ Sports	☐ TENS
☐ Knees Bent	☐ Jogging	☐ Family	☐ E Stim
☐ Legs Up	☐ Running	☐ Friends	☐ Injections
☐ Legs Down	☐ Crawling	☐ Co-workers	☐ Surgery

What HELPS your Overall Problem-s?

☐ Nothing	☐ Standing	☐ Bathing	☐ Working
☐ Rest	☐ Bending	☐ Shower	☐ Heat
☐ Sitting	☐ Twisting	☐ Dressing	☐ Cold
☐ Laying Down	☐ Reaching	☐ Dishes	☐ Therapy
☐ On Side	☐ Lifting	☐ Housework	☐ Massage
☐ On Back	☐ Climbing	☐ Driving	☐ Meds
☐ On Stomach	☐ Walking	☐ Sports	☐ TENS
☐ Knees Bent	☐ Jogging	☐ Family	☐ E Stim
☐ Legs Up	☐ Running	☐ Friends	☐ Injections
☐ Legs Down	☐ Crawling	☐ Co-workers	☐ Surgery

Current Allergies and Sensitivities Mark ALL that APPLY

☐ NONE	☐ Shell Fish	☐ Lidocaine	☐ Phenol	☐ Steroids
☐ Seasonal	☐ Betadine	☐ Marcaine	☐ Glycerin	☐ Latex
☐ Animals	☐ Iodine	☐ Procaine	☐ Cod Liver	☐ Paper Tape
☐ Foods	☐ IVP Dye	☐ Sarapin	☐ Vitamin A	☐ Cloth Tape

Allergies	***What Happens***

☐ Antibiotics:

☐ Other Allergies:

Any Personal History of the following ? Mark ALL that applies and fill in the blanks as needed.

☐ Tobacco Use	☐ Alcohol Abuse	☐ Drug Abuse	☐ Physical Abuse	☐ Sexual Abuse	☐ Violence	☐ Suicide Attempts
☐ Acid / LSD	☐ Club Drugs	☐ Cocaine	☐ Heroin	☐ Inhalants	☐ Marijuana	☐ Ecstasy/MDMA
☐ Meth	☐ PCP	☐ Rx Abuse	☐ Steroids	☐ Caffeine	☐ Soft Drinks	☐ Diet Soft Drinks
☐ Cigarettes	☐ Cigars	☐ Snuff	☐ Chew	☐ Beer	☐ Wine	☐ Liquor
_____ Day	_____ Day	_____ Day	_____ Day	_____ Day	_____ Day	_____ Day
_____ Month	_____ Month	_____ Month	_____ Month	_____ Month	_____ Month	_____ Month

I used ☐ Tobacco products for _____ Years ***I used*** ☐ Alcohol for _____ Years ***I used*** ☐ Drugs for _____ Years

I stopped Tobacco products in _____ ***I stopped*** Alcohol in _____ ***I stopped*** Drugs in _____

Have You ever been Arrested for Drugs or Alcohol Problems? ☐ No ☐ Yes ***Have You ever Served Jail Time?*** ☐ No ☐ Yes

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Name _____ **SSN** **XXX-XX-** _____ **DOB** _____ **Date** _____

Has there been a significant change in your health recently? ☐ NO ☐ YES ***Any recent procedure or hospital visit?*** ☐ NO ☐ YES

What ? _____

Review of Symptoms & Systems ***(NEW MEDICAL PROBLEMS)*** ***Mark ALL that Applies to you recently***

General	☐ Fever	☐ Chills	☐ Night Sweats	☐ Fatigue	☐ Weight Gain	☐ Weight Loss
HEENT	☐ New Headache	☐ Vision Change	☐ Hearing Change	☐ Balance Change	☐ Sinus Problems	☐ Sore Throat
HEENT	☐ Confusion	☐ Memory Issues	☐ Black Outs	☐ Troubled Speech	☐ Can't Swallow	☐ New Weakness
Neurologic	☐ Dizziness	☐ Balance Issues	☐ Trouble Walking	☐ Weakness	☐ Coordination	☐ Dropping Things
Muscular	☐ Weakness	☐ Trigger Points	☐ Cramps	☐ Spasms	☐ Bursitis	☐ Tendonitis
Skeletal	☐ Joint Stiffness	☐ Joint Pain	☐ Bone Pain	☐ Trouble Moving	☐ Sprains / Strains	☐ Fractures
Psychiatric	☐ Mood Changes	☐ Anxiety	☐ Panic Problems	☐ Thought Change	☐ Depression	☐ Suicidal
Cardiac	☐ Chest Pain	☐ Chest Pressure	☐ More Sweating	☐ Nausea	☐ Vomiting	☐ New Arm Pain
Respiration	☐ Breath Shortness	☐ New Cough	☐ Chest Pain	☐ Wheezing	☐ Asthma	☐ Need Oxygen
GI System	☐ Bowel Change	☐ Heart Burn	☐ Gas / Bloating	☐ Diarrhea	☐ Constipation	☐ Bloody Stools
GU System	☐ Bladder Change	☐ Flank Groin pain	☐ Urgency	☐ Burning	☐ Incontinence	☐ Bloody Pee
Sex Organs	☐ Sore Breasts	☐ Groin Pain	☐ Discharge	☐ Sex Problems	☐ Erection Issues	☐ Impotency
Skin	☐ Skin Change	☐ Itching	☐ Rash	☐ Old Sores	☐ New Sores	☐ Bruising
Endocrine	☐ Diabetes	☐ Need Insulin	☐ Energy Change	☐ Hair Changes	☐ Fatigue	☐ Low Sex Drive
Immune	☐ Infections	☐ Hepatitis	☐ TB	☐ AIDS / Related	☐ Tumors /Growth	☐ Cancer
Blood	☐ Blood Disorders	☐ Bleeding	☐ Bruising	☐ Clotting	☐ Swelling / Pain	☐ Blood Thinners
Vessels	☐ Warm Limb	☐ Cold Limb	☐ Red Limb	☐ White Limb	☐ Blue Limb	☐ Black Limb

You had	☐ Heart Attacks	☐ Bypass Surgery	☐ Valve Surgery	☐ Heart Stints	☐ Vein Stripping	☐ Vessel Surgery
You have	☐ Pacemaker	☐ Internal Pump	☐ Stimulator	☐ Metal Implants	☐ Metal Staples	☐ Metal Shavings
You are	☐ Pregnant	☐ Claustrophobic	☐ Anxious	☐ Have High BP	☐ Have Low BP	☐ Dizzy
You take	☐ Antibiotics	☐ Anti-virals	☐ Anti-fungals	☐ Cancer Meds	☐ Steroids	☐ Psych Meds
You take	☐ Blood Thinners	☐ Aspirin	☐ NSAIDS	☐ Plavix	☐ Coumadin	☐ Heart Meds
History Of	☐ Tobacco Use	☐ Caffeine Use	☐ Alcohol Abuse	☐ Drug Abuse	☐ Physical Abuse	☐ Sex Abuse
You still use	☐ Tobacco	☐ Caffeine	☐ Soft Drinks	☐ Alcohol	☐ Other's Meds	☐ Illegal Meds

Current Allergies and Sensitivities ***Anything New?*** ***Mark ALL that Applies to you***

☐ NONE	☐ Phenol	☐ Glycerin	☐ Cod Liver Oil	☐ Vitamin A	☐ Sarapin	☐ Botox
☐ Lidocaine	☐ Marcaine	☐ Procaine	☐ Sea Food	☐ Shell Fish	☐ IVP Dye	☐ Contrast Dyes
☐ Cholor prep	☐ Iodine	☐ Betadine	☐ Steroids	☐ Latex	☐ Paper Tape	☐ Cloth Tape
☐ Seasonal Stuff	☐ Dogs	☐ Cats	☐ Molds	☐ Yeast	☐ Fungus	☐ Dust
☐ OTHER						

What Reactions to you get with your Allergies and Sensitivities? ***Anything New?*** ***Mark ALL that Applies to you***

☐ Rapid Heart	☐ Itching	☐ Rash	☐ Swelling	☐ Bruising	☐ Short Breath	☐ Can't Breath
☐ Can't Swallow	☐ Diarrhea	☐ Constipation	☐ Can't Pee	☐ Nausea	☐ Fainting	☐ Need Epi Pen
☐ Mood Swings	☐ Agitation	☐ Out Bursts	☐ Confusion	☐ Depression	☐ Suicidal	☐ Ned ER Visit
☐ OTHER						

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Name _____ **SSN XXX-XX-** _____ **DOB** _____ **Date** _____

Has there been a significant change in your health recently? ☐ NO ☐ YES ***Any recent procedure or hospital visit?*** ☐ NO ☐ YES

What ? _____

Past Medical History (OLD or LONG TERM MEDICAL PROBLEMS) Mark ALL that your are being treated for

General	☐ Chronic Pain	☐ Chronic Fatigue	☐ Hyper tension	☐ Hypo tension	☐ Sleep Problems	☐ Fibromyalgia
Headaches	☐ New Headache	☐ Migraines	☐ Tension	☐ Cluster	☐ Whiplash	☐ Hormonal
Head Injury	☐ Open Injury	☐ Closed Injury	☐ Concussions	☐ Strokes	☐ TIA's	☐ Tumors
Head	☐ Alzheimer's	☐ Cerebral Palsy	☐ Poor Memory	☐ Poor Attention	☐ Poor Speech	☐ Weakness
Eyes	☐ Blindness	☐ Cataracts	☐ Double Vision	☐ Glaucoma	☐ Poor Vision	☐ Retina Problems
Ears	☐ Balance Issues	☐ Deafness	☐ Dizziness	☐ Ear Ringing	☐ Poor Hearing	☐ Vertigo
Nose	☐ Bloody Nose	☐ Septum Problem	☐ Nasal Polyps	☐ Sinusitis	☐ Snorer	☐ Sleep Apnea
Throat	☐ Poor Speech	☐ High Palate	☐ Poor Swallow	☐ Bad Teeth	☐ TMJ Problems	☐ Dental Work
Cardiac	☐ Heart Attacks	☐ Congested Heart	☐ Valve Disease	☐ Rhythm Issues	☐ Hyper Tension	☐ Hypo Tension
Respiration	☐ Asthma	☐ Bronchitis	☐ COPD	☐ Emphysema	☐ Smoker	☐ Need Oxygen
GI System	☐ Ulcers / Reflux	☐ Liver Disease	☐ Hepatitis	☐ Cirrhosis	☐ Constipation	☐ Diarrhea
	☐ Leaky Gut	☐ High Cholesterol	☐ High Lipids	☐ Gallbladder	☐ Gall Stones	☐ Pancreatitis
	☐ Appendix	☐ Irritable Bowel	☐ Polyps	☐ Diverticulitis	☐ Hemorrhoids	☐ Bloody Stools
GU System	☐ Renal Disease	☐ Bladder Disease	☐ Kidney Stones	☐ Bladder	☐ Incontinence	☐ Infections
Male	☐ Breast Disease	☐ Infections	☐ Testicle Torsion	☐ Prostratitis	☐ Poor Erection	☐ Impotency
Female	☐ Breast Disease	☐ Infections	☐ Ovary Problems	☐ Uterine Issues	☐ Infertility	☐ Menopause
Skin	☐ Rashes	☐ Infections	☐ Scar Tissue	☐ Dry /Oily Skin	☐ Sclerosis	☐ Lots of Sweat
Endocrine	☐ Pituitary Trouble	☐ Thyroid	☐ Estrogen	☐ Progesterone	☐ Testosterone	☐ Vitamin D
Diabetes	☐ Juvenile Onset	☐ Adult Onset	☐ Insulin Needed	☐ Insulin Pump	☐ Meds Controlled	☐ HYPO glycemic
Immune	☐ Infections	☐ Bacterial	☐ Viral	☐ Fungal	☐ Parasites	☐ Tumors
	☐ Hepatitis Active	☐ Hepatitis	☐ STD's	☐ TB	☐ AIDS / Related	☐ Cancer
Blood	☐ Blood Disorder	☐ Anemia	☐ Bleeding	☐ Clotting	☐ DVT / Clots	☐ Blood Thinners
Vessels	☐ Artery Disease	☐ Vein Disease	☐ Vasculitis	☐ Raynaud's	☐ Burger's	☐ Lymph edema
Neurologic	☐ Weakness	☐ Pain	☐ Polyneuropathy	☐ Radiculopathy	☐ Neuritis	☐ Nerve Injuries
Muscular	☐ Weakness	☐ Myocitis	☐ Myopathy	☐ Dystrophies	☐ Dystonia	☐ Atrophy
Skeletal	☐ Osteoarthritis	☐ Osteoporosis	☐ Rheumatoid	☐ Gout	☐ Bursitis	☐ Tendonitis
	☐ Sprains / Strains	☐ Ligament Issues	☐ Tissue Tears	☐ Impingements	☐ Fractures	☐ Compression Fx

Psychiatric	☐ Psychological Disorder	☐ Attention Disorder	☐ Anxiety / Panic Disorder	☐ Claustrophobia
	☐ Depression	☐ Manic Depression	☐ Mood Disorder	☐ Obsessions
	☐ Personality Disorder	☐ Post Traumatic Stress	☐ Schizophrenia	☐ Suicidal Thoughts
	☐ Suicidal Attempts	☐ Thought Disorder	☐ Work Swing Shift	☐ History of Violence
	☐ Alcohol Abuse	☐ Drug Abuse	☐ Physical Abuse	☐ Sexual Abuse

Cancer-s _____ ☐ Radiation Txs ☐ Chemotherapy

OTHER _____

OTHER _____

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PAST INJURY HISTORY ***Mark all that apply and fill in the blanks as indicated***

	None	Number		None	Number		None	Number
Open Head Injuries	☐	_____	Closed Head Injuries	☐	_____	Concussions	☐	_____
Neck Injuries	☐	_____	Upper Back Injuries	☐	_____	Low Back Injuries	☐	_____
Auto Accidents	☐	_____	Work Accidents	☐	_____	Personal Accidents	☐	_____

What Bad Sprain / Strains _____

What Fractures _____

What Trauma Surgery-ies _____

What Trauma Surgery-ies _____

PAST SURGERY HISTORY ***Mark all that apply and Fill in the blanks as indicated***

Head	_____	Breast-s	_____
Eyes	_____	Uterus	_____
Ears	_____	Ovaries	_____
Nose	_____	Vagina	_____
Mouth	_____	Prostrate	_____
Teeth	_____	Testicles	_____
Throat	_____	Penis	_____
Neck	_____	Kidney-ies	_____
Chest	_____	Bladder	_____
Heart	_____	Blood Vessels	_____
Lungs	_____	Arteries	_____
Esophagus	_____	Veins	_____
Abdomen	_____	Skin	_____
Stomach	_____	C-Spine	_____
Small Intestine	_____	T-Spine	_____
Gallbladder	_____	LS-Spine	_____
Liver	_____	Bones / Joint-s	_____
Pancreas	_____	Bones / Joint-s	_____
Spleen	_____	_____	_____
Appendix	_____	_____	_____
Large Intestine	_____	_____	_____
Colon	_____	_____	_____
Rectum	_____	_____	_____

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Family Medical History Any Problems with Any of the following? Anything Else? Mark All That Applies

☐ Heart Disease	☐ High BP	☐ Low BP	☐ Stroke	☐ Cancer	☐ Diabetes	☐ Obesity
☐ Bruising	☐ Bleeding	☐ Clotting	☐ Thyroid	☐ Seizures	☐ Osteoporosis	☐ Glaucoma
☐ Smoking	☐ Alcohol Abuse	☐ Drug Abuse	☐ Physical Abuse	☐ Sexual Abuse	☐ Suicides	☐ Violence
☐ Depression	☐ Suicide	☐ Separations	☐ Divorce	☐ Disability	☐ Legal Problems	☐ Family in Jail

☐ Psychological Disorder	☐ Attention Disorder	☐ Panic Disorder	☐ Claustrophobia	☐ _____
☐ Personality Disorder	☐ Post Traumatic Stress	☐ Schizophrenia	☐ Suicidal Thoughts	☐ _____
☐ Panic Disorder	☐ Manic Depression	☐ Mood Disorder	☐ Obsessions	☐ _____

☐ *OTHER* _____

☐ *OTHER* _____

Personal Social Functional History Mark All That Applies

You are ☐ Single ☐ Never Married ☐ Have a significant other ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

You live with ☐ Live alone ☐ Room Mate ☐ Friends ☐ Significant other ☐ Spouse ☐ Guardian ☐ In-Laws

You live with ☐ Family ☐ Parent-s ☐ Step Parent-s ☐ Grandparent-s ☐ Kid-s ☐ Sibling-s ☐ Step Sibling-s ☐ Grandkids

How many places do you live at ☐ One ☐ Two ☐ Three ☐ More _____ ☐ School ☐ Main home ☐ Seasonal / Vacation home

You live in a ☐ Homeless ☐ House ☐ Condo ☐ Dorm ☐ Apartment ☐ Mobile Home ☐ Skilled Living ☐ Nursing Home

How many PAIN Doctor-s have you seen in the Past ☐ _____ ***How many PAIN Doctor-s are you still seeing Now*** ☐ _____

Do or did they all work in your Local town or City ☐ Yes ☐ No ***How many different cities or towns are they located*** ☐ _____

Did or do you have to go to Another State-s for care ☐ Yes ☐ No ***What State-s*** ☐ _____

Do you still have to go to Another State-s for care ☐ Yes ☐ No ***What State-s*** ☐ _____

Have you ever had your pain prescriptions Lost ☐ Yes ☐ No ***How many times*** ☐ _____ ***I Got it back*** ☐ Yes ☐ No

Have you ever had your pain prescriptions Stolen ☐ Yes ☐ No ***How many times*** ☐ _____ ***I Got it back*** ☐ Yes ☐ No

Do you get your Medicines from the Doctors Office ☐ Yes ☐ No ***How Many Different Pharmacies do you use*** ☐ _____

Are you as good as you think you can get ☐ Yes ☐ No ***What do you want*** _____

How Often do you see your pain medicine doctor ☐ When ever I need to go ☐ Every _____ Week-s ☐ Every _____ Month -s

How Many Miles do you travel to see the pain doctor ☐ Less than 25 ☐ 25 to 50 ☐ 50-75 ☐ 75 –100 ☐ About _____ Mile -s

Personal Adaptive Equipment that you use Mark ALL that applies and fill in the blanks as needed.

☐ Glasses ☐ Bi-focals ☐ Contacts ☐ Dentures ☐ Partials ☐ Hearing Aid ____ RT ____ Lft ☐ Cane ____ RT ____ Lft

☐ TENS unit ☐ E Stim unit ☐ FES Unit for Foot Drop ____ Right ____ Left ☐ FES Unit for Wrist Drop ____ Right ____ Left

☐ Crutches ☐ Walker ☐ Wheeled Walker ☐ Wheelchair ☐ Scooter ☐ Electric Wheelchair ☐ Adaption's done for vehicle

Traction ☐ Inversion Device ☐ Low Back Gravity ☐ Low Back Pneumatic ☐ Neck over door unit ☐ Neck Pneumatic

Compression Supports or Stockings _____

What Limb, Spine and Neck Braces _____

DIET: Are You on a Special Diet?

☐ Regular ☐ Diabetic ☐ Gluten Free ☐ Vegetarian ☐ Weight Loss ☐ Low Glycemic ☐ High Protein ☐ Low Carbs

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WHAT PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS ARE YOU TAKING?
PLEASE INCLUDE TOPICAL CREAMS, PACTHES, OINTMENTS, HERBS, VITAMINS & SUPPLIMENTS

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE	# pills/patch	HOW OFTEN	**DAY TOTAL**
______	______	______ per hrs	______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ____________
It is used for? ____________
Side Effects? ____________

DOSE	# pills/patch	HOW OFTEN	**DAY TOTAL**
______	______	______ per hrs	______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

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Medication ______________________

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Side Effects? ______________________

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Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

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Side Effects? ______________________

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Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

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Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less