
Name	Age	Today's Date
-------------	------------	---------------------

1. Where are your chief areas of pain? Please circle all those that apply below:
Head Neck Upper Back Lower Back Shoulder Arm Buttocks Legs

2. Date of Injury _____ **Work Related?** *Yes no* **Auto Accident?** *Yes no*

3. Please describe your injury _____

4. If you have weakness please indicate where? _____

5. If you have numbness please indicate where? _____

6. If you have headaches caused by this injury, how often? _____

6a. If so, what part of your head is affected? *Front back top side behind eyes*

7. Please list the names of all the medications you are taking _____

8. Indicate if you've had any of these tests & the results as you understand them:

X-rays MRI Cat Scan EMG Myelogram Discogram Bone Scan

Results: _____

9. Which of the following treatments have you had for your current problem?

Heat, ice, electrical stim, traction, physical therapy, chiropractic, acupuncture, yoga, pilates, trigger point injections, x-ray guided spinal injections

10. Who is your primary care doctor? _____ **Last visit?** _____

11. Who else have you seen about your current problem? _____

12. Have you ever had similar problems in the past? _____

13. What medications are you allergic to? _____

14. What side effects have you had with meds? _____

15. When was your last complete physical exam? _____

16. What medical problems do you have? _____

17. What surgeries have you had? _____

18. Indicate if you have had any of the following in the past 6 months:

- | | | |
|---|---|---|
| <input type="checkbox"/> unexplained weight gain / loss | <input type="checkbox"/> yellow jaundice | <input type="checkbox"/> shortness of breath with normal activities |
| <input type="checkbox"/> appetite change | <input type="checkbox"/> ulcer | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> uncontrolled loss of stool | <input type="checkbox"/> difficulty with urination |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> blood in stool, | <input type="checkbox"/> kidney infection |
| <input type="checkbox"/> night sweats | <input type="checkbox"/> constipation | <input type="checkbox"/> loss of bladder control |
| <input type="checkbox"/> fever | <input type="checkbox"/> pain with bowel movements | <input type="checkbox"/> recurrent cough |
| <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> chest pain | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> joint pain | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> joint stiffness | <input type="checkbox"/> blood clots | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> redness | <input type="checkbox"/> heart attack | |
| <input type="checkbox"/> swelling | <input type="checkbox"/> general heart problems | |
| <input type="checkbox"/> recurrent belly pain | | |
| <input type="checkbox"/> Heartburn | | |

Women only: breast pain, discharge, or lump.

19. What illnesses run in your immediate family? _____

20. Do you smoke? *Yes no* **How many years?** _____ **How many packs per day?** _____

21. Have you used illicit drugs? *Yes no* **How often and which ones?** _____

22. Do you drink alcohol? *yes no* **How often?** _____

23. If you have ever been on disability, when and for what? _____

24. Occupation: _____ **When was your last day of work?** _____

25. Do you have an attorney for this injury? *Yes no* **Do you plan to get one?** *Yes no*

26. Relative to your current problem, have you been happy with the treatment you have received up to this time? *Yes no*

27. List any activity limitations you are currently experiencing? _____

28. What do you wish to accomplish in today's visit? _____

I attest that the information noted above accurately represents my symptoms and medical history.

your signature

(Thank you for your effort to complete this form. The information is essential to Dr. Zaman)