CENTER FOR NEUROLOGICAL DISORDERS, PA

Patient Name _____ Date of Birth _____/_____/_____

Home Ph (____)_____ Work Ph (____)_____ Mobile Ph (____)_____

Email Address _____ Today's Date _____/_____/_____

Home Address _____

Primary reason for consultation? **(not imaging results)** _____

BACKGROUND INFORMATION

Age _____ ☐ Left-handed ☐ Right-handed ☐ Male ☐ Female

Height _____ft _____in Weight _____lbs Weight (1 year ago) _____

Who referred you for this appointment? _____

Who is your primary care physician? _____

Other physicians seen for this problem? _____

Please check, as appropriate, the boxes below as they pertain to your injury or condition.

☐ Worker's compensation claim ☐ Personal injury lawsuit pending ☐ Criminal or Civil lawsuit pending

THERAPIES TRIED

PLEASE CHECK, AS APPROPRIATE, THERAPIES YOU HAVE UNDERGONE FOR YOUR CURRENT CONDITION.

☐ Physical therapy ☐ Chiropractic treatment ☐ Psychological counseling

☐ TENS unit ☐ Massage therapy ☐ Relaxation training

☐ Low impact exercise as tolerated (e.g. walking, swimming, stationary bike)

☐ Exercise program (structured or self-directed) ☐ Yoga or Pilates

☐ Acupuncture ☐ Other _____

PLEASE CHECK, AS APPROPRIATE, PROCEDURES YOU HAVE UNDERGONE FOR YOUR CURRENT CONDITION.

☐ Epidural steroid injection (s) ☐ Selective nerve root block(s) ☐ Facet injection/block

☐ Facet rhizotomy ☐ Spinal cord stimulator ☐ IDET

☐ Trigger point injections ☐ Discography ☐ Radiofrequency ablation

☐ Medial branch block(s) ☐ Laser procedure

☐ Previous surgery _____

☐ Other _____

PAIN EVALUATION

IF YOUR CONSULTATION IS RELATED TO A COMPLAINT OF PAIN, PLEASE COMPLETE THIS PAGE.

WHERE IS THE PAIN LOCATED? _____ WHEN DID IT BEGIN? _____

Does it spread or radiate? ☐Yes ☐ No Describe _____

Caused by a specific injury? ☐Yes ☐ No Describe _____

RATE YOUR PAIN INTENSITY WITH AN **X** ON THE LINES BELOW (0 = NO PAIN, 10 = WORST IMAGINABLE)

WORST PAIN 0_____10

LEAST PAIN 0_____10

USUAL PAIN 0_____10

INDICATE HOW THE FOLLOWING ACTIVITIES AFFECT THE PAIN (W = WORSE, N = NO AFFECT, B = BETTER)

Lying down _____ Sitting _____ Standing _____ Walking _____ Cough/Sneeze _____

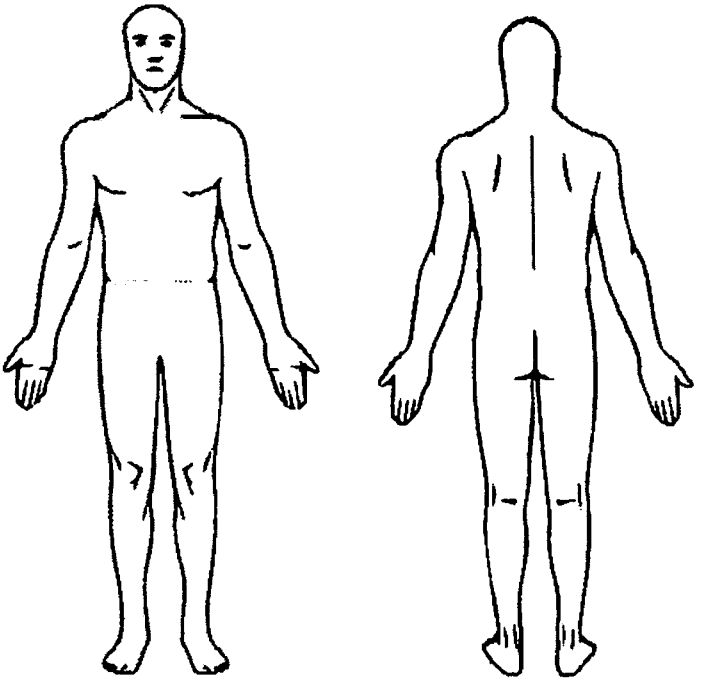
FACTORS THAT MAKE PAIN BETTER? _____

FACTORS THAT MAKE PAIN WORSE? _____

HOW DOES PAIN INTERFERE WITH DAILY ACTIVITIES? _____

_____

MARK ON THE FIGURES ALL PAINFUL AREAS USING THE SYMBOLS LISTED BELOW



----------	oooooooooo	xxxxxxxxxx	//////////	++++++++++
Numbness	Pins/Needles	Burning	Stabbing	Aching

PERSONAL MEDICAL HISTORY

MEDICAL PROBLEMS (e.g. diabetes, lung disease)

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.

CURRENT MEDICATIONS (dose and frequency)

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.

PREVIOUS SURGERIES (what? when?)

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

ALLERGIES (medications, latex, food, etc)

1.
2.
3.
4.
5.
6.

NUTRACEUTICALS (herbal or dietary supplements, diet pills, vitamins, minerals, etc)

1.
2.
3.
4.
5.
6.

FAMILY MEDICAL HISTORY

	LIVING?	IF NO, AGE AT DEATH	IF DECEASED, FROM WHAT ILLNESS?	MEDICAL PROBLEMS
Father	☐ Yes ☐ No			
Mother	☐ Yes ☐ No			

	HOW MANY TOTAL?	ARE ANY DECEASED?	IF DECEASED, FROM WHAT ILLNESS?	MEDICAL PROBLEMS
Brother(s)				
Sister(s)				
Son(s)				
Daughter(s)				

SOCIAL HISTORY

CURRENT MARITAL STATUS? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Committed relationship

HIGHEST EDUCATION COMPLETED? ☐ Elementary ☐ Jr. high ☐ High school ☐ College ☐ Post-Graduate

HAVE YOU EVER SMOKED CIGARETTES? ☐ Yes ☐ No ARE YOU CURRENTLY A SMOKER? ☐ Yes ☐ No
#packs/day? _____ How many years? _____

HAVE YOU EVER QUIT SMOKING? ☐ Yes ☐ No How long ago?_____ For how long? _____

DO YOU USE OTHER TOBACCO PRODUCTS? ☐ Yes ☐ No What type? _____ For how long? _____

DO YOU DRINK ALCOHOL? ☐Yes ☐ No How many drinks? _____ How often (daily, weekly, etc)? _____

DO YOU USE ANY RECREATIONAL DRUGS? ☐Yes ☐No What type? _____ How often? _____

WORK HISTORY

CURRENT EMPLOYMENT STATUS? ☐ Employed ☐ Retired ☐ Unemployed ☐ Sick leave ☐ Sabbatical
☐ Leave of absence ☐ Student ☐ Stay at home parent ☐ Disability -- if so, since when? _____

EMPLOYER? _____ JOB TITLE? _____ For how long? _____

WHAT IS YOUR WORK SCHEDULE? _____

MOVEMENTS REQUIRED FOR YOUR JOB? ☐ Pushing ☐ Pulling ☐ Sitting ☐ Standing ☐ Climbing stairs
☐ Climbing ladders ☐ Bending ☐ Twisting ☐ On hands and knees ☐ Squatting ☐ Lifting _____ pounds
☐ Reaching above shoulders ☐ Repeated wrist/hand movements

ABLE TO PERFORM USUAL DUTIES? ☐ Yes ☐ No HAVE YOUR DUTIES BEEN MODIFIED? ☐ Yes ☐ No

HOW MUCH WORK HAVE YOU MISSED BECAUSE OF THIS CONDITION? _____

REVIEW OF SYSTEMS

CONSTITUTIONAL

- ☐ Fever
- ☐ Weight loss
- ☐ Fatigue
- ☐ Night sweats
- ☐ History of cancer
  - Type _____
  - Year diagnosed _____
  - ☐Radiation ☐ Chemotherapy ☐ Surgery

EYES

- ☐ Corrective lenses or contacts
- ☐ Lasik surgery
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Double vision

EARS, NOSE, THROAT, AND MOUTH

- ☐ Hearing loss
- ☐ Tinnitus (ringing in ears)
- ☐ Imbalance or vertigo
- ☐ Nasal discharge or chronic sinus congestion
- ☐ Loss of smell or taste

CARDIOVASCULAR

- ☐ Angina (chest pain)
- ☐ High blood pressure
- ☐ Atrial fibrillation
- ☐ Irregular pulse or palpitations
- ☐ Heart murmur
- ☐ High cholesterol
- ☐ History of heart attack
- ☐ Congestive heart failure

RESPIRATORY

- ☐ Asthma
- ☐ COPD
  - ☐ Chronic bronchitis ☐ Emphysema
- ☐ Shortness of breath at rest
- ☐ History of pneumonia
- ☐ Bloody sputum

GENITOURINARY

- ☐ Frequent urinary infections
- ☐ Painful urination
- ☐ Incontinence
- ☐ Kidney or bladder stones
- ☐ Prostate enlargement

GASTROINTESTINAL

- ☐ Heartburn
- ☐ Frequent nausea or vomiting
- ☐ Liver disease
- ☐ History of ulcers
- ☐ Irritable bowel disease
- ☐ Diverticulitis

MUSCULOSKELETAL

- ☐ Degenerative arthritis
- ☐ History of joint replacement
- ☐ Gout

INTEGUMENT (SKIN)

- ☐ Psoriasis
- ☐ New stretch marks
- ☐ History of skin cancer

NEUROLOCIAL

- ☐ Stroke or TIA
- ☐ Tremors
- ☐ Seizure/Epilepsy
- ☐ Speech disorder/loss
- ☐ Loss of coordination
- ☐ Disorientation/Confusion

ENDOCRINE

- ☐ Thyroid disease
- ☐ Diabetes mellitus
  - ☐Type I ☐ Type II
- ☐ Constant thirst
- ☐ Nipple discharge or galactorrhea

HEMATOLOGIC

- ☐ Bleeding or clotting disorder
- ☐ Deep venous thrombosis (DVT)
- ☐ Hemophilia

INFECTIOUS

- ☐ Meningitis
- ☐ Risk for exposure to HIV
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ History of blood transfusion

PSYCHIATRIC

- ☐ Depression
- ☐ Bipolar disorder
- ☐ Obsessive-Compulsive disorder
- ☐ ADD/ADHD

PATIENT SIGNATURE _____ DATE _____