DESERT SKY
SPINE & SPORTS MEDICINE

Name_____ Age _____ Date _____

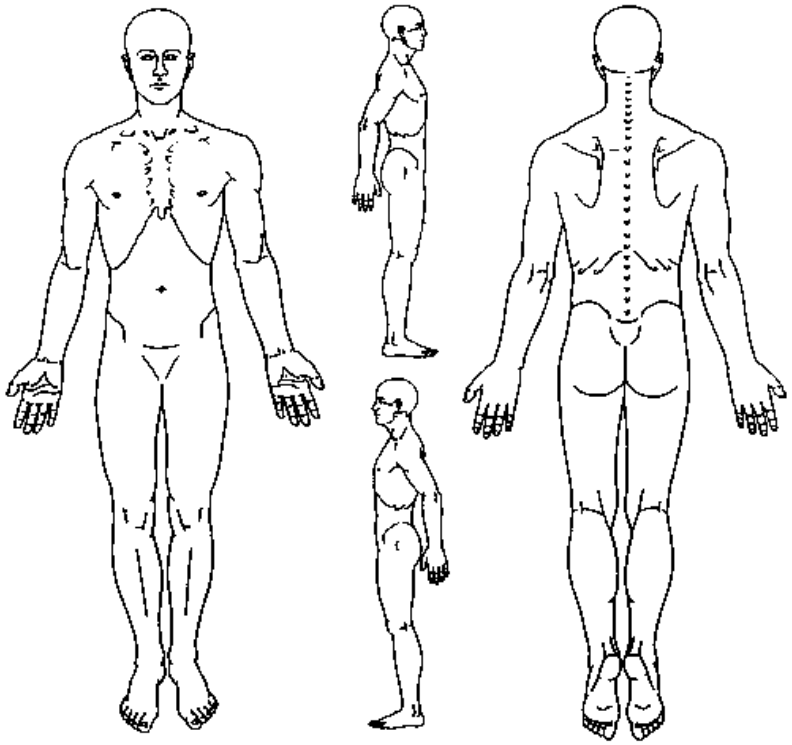
Referring Physician/Therapist_____

Primary Care Physician_____

Reason for Visit _____

If you are having pain, use the diagram and symbols to indicate where it is.

Ache: AAA Burning:XXX Numbness:OOO Pins/Needles: …… Stabbing://///



Approximate Date Symptoms Started _____

Describe how your symptoms started (i.e., describe how the injury occurred)

_____

_____

_____

Describe your current symptoms

_____

_____

_____

_____

_____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Briefly describe any treatment you have had thus far

(Physicians, Chiropractors, Physical Therapists)

_____

_____

_____

_____

_____

Circle any of the following you have had for your symptoms:

X-ray CT Scan MRI EMG/NCS Epidurals

Please list any medications, natural supplements, and vitamins you taking:

Medication	Dose	Frequency	Medication	Dose	Frequency

If more space is required, please use other side of page or attach medication list

List any allergies you have, or medications you have had adverse reactions to, including contrast and shellfish allergy:_____

PAST MEDICAL HISTORY

☐Anxiety ☐Heart Attack ☐Polio ☐Thyroid trouble ☐Depression

☐Hypertension ☐Asthma ☐Heart Murmur ☐Stroke ☐High Cholesterol

☐Alcoholism ☐Liver disease ☐Cancer ☐Lung Disease

☐Parkinson's ☐Rheumatic Fever ☐Hepatitis ☐Chronic pain

☐Diabetes ☐Ulcers/PUD ☐Arthritis ☐Claustrophobia ☐Other_____

Have you ever had similar symptoms/injury before? ☐No ☐Yes

If yes, when: _____ Please describe briefly: _____

_____

Have you ever been diagnosed with fibromyalgia or chronic fatigue syndrome?_____

PAST SURGICAL HISTORY

Have you had any surgeries? ☐No ☐Yes

If yes, please list type of surgery and approximate date:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

FAMILY HISTORY

Please check box for any medical condition that a blood relative has a history of:

☐Anxiety ☐Heart Attack ☐Polio ☐Thyroid trouble ☐Depression

☐Hypertension ☐Asthma ☐Heart Murmur ☐Stroke ☐High Cholesterol

☐Alcoholism ☐Liver disease ☐Cancer ☐Lung Disease ☐Parkinson's

☐Rheumatic Fever ☐Hepatitis ☐Chronic pain ☐Diabetes ☐Ulcers/PUD

☐Arthritis ☐Claustrophobia ☐Psychiatric illness ☐Other _____

SOCIAL HISTORY

Marital Status: (Check one or more)

☐Single ☐Married ☐Divorced ☐Widowed ☐"Living together" ☐Separated

Number of children: _____ Ages: _____ _____ _____ _____ _____ _____

Do you smoke? ☐No ☐Yes How much? _____

Previous Smoker? ☐No ☐Yes When stopped? _____

Do you drink alcohol? ☐No ☐Yes How much? _____

Coffee, tea, cola beverages (cups/glasses/cans per day) _____

Do you use recreational drugs? ☐No ☐Yes What type/how often? _____

Are you currently employed? ☐No ☐Yes If yes, type of job _____

If you exercise regularly, what types of activities/sports do you enjoy? _____

_____

REVIEW OF SYSTEMS Please mark those items which you currently experience:

GENERAL

☐Fever ☐Weight gain ☐Weight loss ☐Fatigue ☐Chills

☐Weakness ☐Night sweats

DERMATOLOGIC

☐Jaundice ☐Itching/rash ☐Lesions ☐Easy bruising

HEAD/HEARING & VISION

☐Trauma ☐Headaches ☐Tenderness ☐Dizziness

☐Ringing in ears ☐Blindness ☐Blurred vision

☐Changes/loss ☐Discharge ☐Rings around lights

☐Double vision ☐Light sensitivity ☐Glasses

PULMONARY

☐Wheezing ☐Shortness of breath ☐Chronic cough ☐Coughing up blood

CARDIOVASCULAR

☐Chest pain ☐Leg swelling ☐Shortness of breath with exertion ☐Racing heart

GASTROINTESTINAL

☐Nausea ☐Abdominal pain ☐Bloody stool ☐Constipation ☐Diarrhea

☐Vomiting ☐Stool color changes ☐Heartburn ☐Incontinence of bowels

GENITOURINARY

☐Blood in urine ☐Vaginal discharge ☐Pregnancy

☐Pain/burning on urination ☐Incontinence ☐Venereal disease ☐Sexual problem

☐Painful menstruation ☐Menopause ☐Urgency/frequency with urination

☐Irregular menstruation

MUSCULOSKELETAL

☐Arthritis ☐Joint swelling ☐Trauma

NEUROLOGICAL

☐ Loss of Sensation ☐ Seizures ☐ Numbness and Tingling

PSYCHOLOGICAL

☐Sadness ☐ Anxiety ☐ Depression

(OPTIONAL) Please check any of the following statement if it something you have said or might say:

____I don't really like doctors. I try to stay away from them as much as possible.

____I have been everywhere, and no one seems to understand me or my pain.

____I read about everything on the internet. I have read all about my condition.

____The only thing that seems to help me is pain medication.

____I prefer my doctor to make the plan of care for me. I will basically do what he or she wants.

____I prefer to avoid surgery if I can.

____Find it, fix it. However aggressive you need to be.

____I don't like taking medications. I only take natural products.