PROVIDENCE
St. Mary
Neuroscience Institute

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Height:_____ Weight: _____

Primary Care Provider:_____ Who Referred:_____

If not referred, how did you choose this office? _____

Why are you seeing the doctor today? _____

_____

Please list major complaint(s) and describe their onset (i.e., lower back pain began in May 2012 after lifting):

_____

_____

Are you having any? □ Numbness Where? _____
□ Weakness Where? _____
□ Loss of bowel or bladder control

What makes your symptoms better (please circle all that apply): Nothing, rest, changing position, standing, sitting, walking, running, kneeling, bending, twisting.

What worsens your symptoms (please circle all that apply): Nothing, rest, changing position, standing, sitting, walking, running, kneeling, bending, twisting.

Is this visit related to an injury? □ Yes □ No On the job? □ Yes □ No

If so, date of injury: _____ Date of last employment:_____

Do you have any open worker's compensation claims of any kind? □ Yes □ No

Do you have a lawsuit pending? □ Yes □ No

Please circle the description which applies to your intensity of pain: Stable, unchanged, gradually worsening, rapidly worsening, gradually improving, rapidly improving, completely resolved.

How long has the problem been present? _____ Day(s), _____ Week(s), _____ Month(s), _____ Year(s)

What started the pain/problem? _____

Quality of the pain (mark up to four): □ Sharp □ Shooting □ Crushing □ Tight Band
□ Numbing □ Pulsating □ Aching
□ Tingling □ Dull □ Throbbing

How severe is the pain at the location described above? □ No Pain □ Mild □Moderate □ Severe

Is the pain (check all that apply)? □ Rare □ Infrequent □ Occasional □ Intermittent
□ Daily □ Continuous □ Weekly □ Monthly

What treatments have you tried for this problem?

□ Physical Therapy □ TENS units □ Narcotic Medications □ Muscle Relaxers
□ Massage □ Traction □ Anti-inflammatories □ Orthotics
□ Chiropractor □ Surgery □ Steroid injections □ Braces
□ Other: _____

Previous physicians seen for this problem?

Physician	Specialty	City	Treatment

PAST MEDICAL HISTORY: Check all that apply □ None Apply

□ Abnormal heartbeat □ Cirrhosis □High blood pressure Neuropathy: □ Hands □ Feet
□ ADHD □ Depression □High cholesterol □ Poor circulation
□ Anemia □ Down syndrome □ HIV/AIDS □ Seizure
□ Anxiety □ Emphysema □ Kidney failure □ Spina bifida
□ Asthma □ Gastric reflux □ Kidney stones □Stomach ulcers
□ Bleeding disorder □ Gout □Migraine □ Stroke
□ Blood clots in leg □ Heart attack □ Multiple Sclerosis (MS) □ Thyroid
□ Blood clots in lung □ Heart failure □ Neurofibromatosis □ Tuberculosis
□ Cerebral palsy □ Hepatitis B or C □ Osteoporosis □ Fibromyalgia
□ Osteoarthritis □ Rheumatoid arthritis □ Other Rheumatological Disease

Cancer: _____(type/treatment)

□ Diabetes: If yes, when was it diagnosed? _____
Currently controlled with: □ insulin □ oral medications □ diet

□ Other : _____

_____

PAST SURGICAL HISTORY:

□ No prior surgery

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia? □ Yes □ No

If yes, have you had any problems related to this? □ Yes □ No

Explain any problems with general anesthesia: _____

SOCIAL HISTORY: Work status

□ Working □ Homemaker □ Unemployed □ Disabled □ On leave □ Retired □ Student

Occupation:_____

Education:_____

Marital status: □ Single □ Married □ Divorced □ Widowed

Children: □No □ Yes, how many? _____

Do you live alone? □ Yes □ No If no, who lives with you? _____

Are you currently smoking? □ Yes □ No If yes, how many pack/day? _____ And for how many years? _____

Have you previously quit smoking? If so, when did you quit? _____ How many years did you smoke? _____

How many packs a day did you previously smoke? _____ Other forms of tobacco used? _____

Alcohol use: □ Never □ Rare □ Social □ Frequently (more than twice a week)
□ Alcoholic □ Recovering alcoholic

Illegal drug use: □ Never □ In the past □ Currently □ Types of drugs? _____

Sexually active: □ Yes □ No

FAMILY HISTORY: Please fill in the illness information below with the options listed:

Alcoholism	Cancer	High blood pressure	Other Rheumatological Disease
Arthritis	Diabetes	Kidney problems	Seizure
Bleeding problems	Gout	Lung problems	Stroke
Blood clots	Heart problems	Mental Illness	

Other: _____

_____

FAMILY MEMBER	ILLNESS	AGE	IF DECEASED, AGE AT DEATH AND CAUSE
Father			
Mother			
Brother(s)			
Sisters			
Children			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Paternal Uncle			
Paternal Aunt			
Maternal Uncle			
Maternal Aunt			

Family History Unknown □

Adopted □

PAIN DIAGRAM

On the diagram below, please indicate where you are experiencing pain or other symptoms.

Use the following to describe your symptoms:

A = Ache

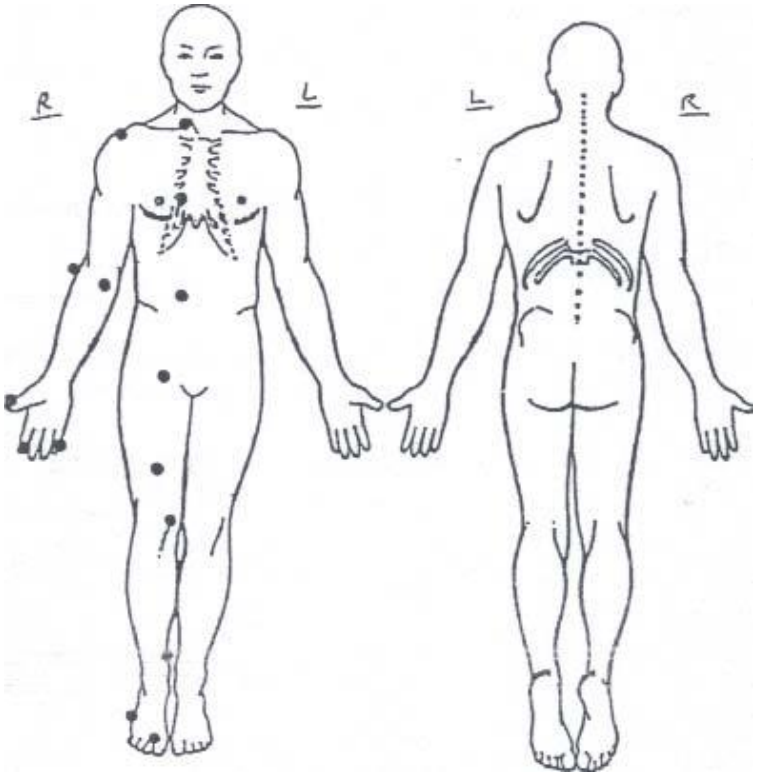
B = Burning

N = Numbness

P = Pins & Needles

S = Stabbing

O = Other



Please rate your usual level of pain on the following scale (circle one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Patient's signature: _____ Provider signature: _____

Date: _____ Date: _____