Bradenton Location
6815 14th Street West, Suite 204
Bradenton, FL 34207
(941) 758-7300

Sarasota Location
2325 South Tamiami Trail
Sarasota, FL 34239
(941) 758-7300

Name: ______________________________ Age: ____________ Date: __________________

Chief Complaint
Why have you come to see the doctor today? ____

Names of doctors seen in the last six months: ____

History of present illness
(Date of Accident)
____
____

Past Medical History
Have you had any health problems in the past? Yes ______ No ______ if yes, list each problem and date.
____
____

	Yes	No		Yes	No		Yes	No		Yes	No
High Blood Pressure	_____	_____	Blood Problems	___ _	_____	Kidney Disease	_____	_____	Stroke	_____	_____
Stomach Ulcers	_____	_____	Heart Disease	_____	_____	Tuberculosis	_____	_____	Lupus	_____	_____
Rheumatoid Arthritis	_____	_____	Lung Disease	_____	_____	Liver Disease	_____	_____	Diabetes	_____	_____
Sinus Infections	_____	_____	Skin Disorders	_____	_____	Thyroid Disease	_____	_____	Cancer	_____	_____

Past Surgical History

Year	Operation	Hospital	Doctor	Year	Operation	Hospital	Doctor
______	___________	____________	___________	______	____________	_____________	___________
______	___________	____________	___________	______	____________	_____________	___________
______	___________	____________	___________	______	____________	_____________	___________

Medications
Please list all medications you take. Please write dosage and how often you take the medication.
____
____

Are you allergic to any medications: Yes _____ No _____ if yes, please list the medications.
____
____

Social History

What type of work do you do? ________________________________ Education Level ________________

Have you ever smoked? Yes _____ No _____ if yes, how many packs per day? _____ How many years? _____ If you have stopped when was the last time you smoked? ________________

Do you currently drink alcohol? Yes _____ No _____ if yes, how much? ________________

Please circle your marital status: Single Married Divorced Widowed

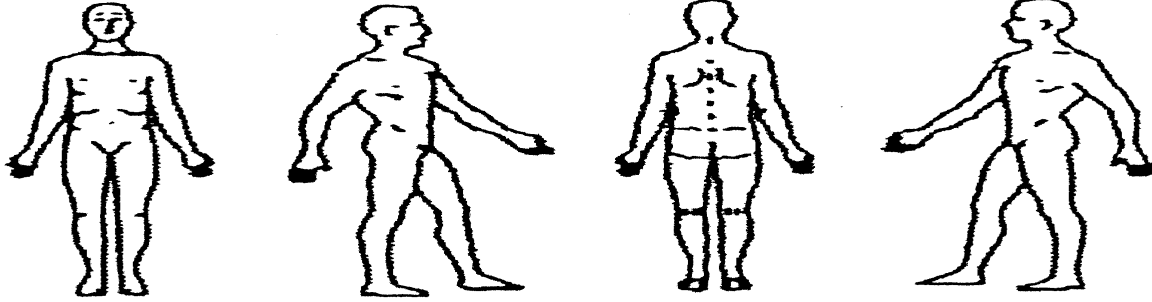
Do you live alone, with someone else, or in a group setting such as a nursing home? ____________________________

Attorney representing you: ________________ Number of previous claims/lawsuits ______________________

Any prior history of drug or alcohol abuse ____

PAIN HISTORY (HISTORY OF PRESENT ILLNESS)

Location – Please shade all areas covered by you pain(s)



Alleviating Factors – What makes the pain better?

___ Hot packs
___ Cold packs
___ Warm showers or baths
___ Medications
___ TENS
___ Nerve Blocks
___ Physical Therapy
___ Walking
___ Bending
___ Sleeping
Chiropractic manipulation
___ Acupuncture
___ Biofeedback
___ Relaxation therapy
___ Psychotherapy
___ Hypnosis
___ Resting
___ Sitting
___ Standing
___ Lying down
___ Using a Brace

Cause of your pain – What started it?

___ Work-related accident or event
___ Motor vehicle accident
___ Unknown event
___ Other (Briefly explain)

____
____
____
____

Severity

___ Getting Better
___ Getting Worse
___ No change since onset

Please indicate from zero to ten, how bad your pain is:
(1) At its worse: _______/10
(2) At its best: _______/10
(3) Now: _______/10
(4) Most of the time: _______/10

Timing – When is the pain worse?

___ Morning
___ Afternoon
___ Nights
___ All of the time
___ During activity or exercise
___ After activity
___ After immobility

Aggravating Factors – What has made it worse?

___ Motion
___ Walking
___ Standing
___ Lifting
___ Bending
___ Squatting
___ Climbing
___ Sitting
___ Surgery

Associated Problems

___ Tingling
___ Numbness
___ Spasms
___ Sweating
___ Temperature changes
___ Color changes
___ Inability to control bladder
___ Inability to control bowel
___ Constipation
___ Erectile dysfunction
___ Impotence
Personality changes
___ Depression
___ Sadness
___ Suicidal Ideation
___ Swelling
___ Nausea
___ Vomiting
___ Dizziness
___ Day-time Cramps
___ Night-time Cramps
___ Fatigue
___ Nervousness
Inability to concentrate

Quality – Which of the following describes your pain?

___ Constant
___ Intermittent
___ Burning
___ Tingling
___ Agonizing
___ Throbbing
___ Nagging
___ Cramping
___ Work-related
Annoying
___ Getting longer
___ Getting shorter
___ Aching
___ Fearful
___ Gnawing
___ Superficial
___ Pressure-like
___ Deep
___ Itching
Dull
___ Sharp
___ Shooting
___ Sickening
___ Stabbing
___ Tender
___ Exhausting
___ Distressing
___ Pulsating
___ Uncomfortable
Disabling

Previous Examination or Tests

___ X-Rays
___ CT scans
___ MRI scans
___ CPT
___ Myelogram
___ Epidurogram
___ CT-Myelogram
Spinal Taps
___ EMG/PNCY
___ Nerve conduction test
___ Discograms
___ Bone scans
___ Orthopedic Evaluation
___ Neurological Evaluation
___ Neurosurgical Evaluation
Chiropractic Evaluation
___ Nerve Blocks
___ Endoscopy
___ Biopsy

Previous Treatments

___ Trigger Point injections
___ Epidural steroid injection
___ Cryoanalgesia
___ Radiofrequency
___ Spinal Cord Stimulator
___ TENS
___ Hypnotherapy
___ Pool exercises
Chiropractic manipulations
___ Morphine Pump
___ Physical Therapy
___ Biofeedback
___ Relaxation Therapy
___ Stretching exercise
___ Strengthening exercise
___ Tractions
___ Facet Blocks
Narcotic medications

PATIENT SIGNATURE: ____ DATE: ___________________________

MD SIGNATURE: ____ DATE: ___________________________