Dr. Carol Sue Carlson – new patient form

PHYSICAL THERAPY

☐ YES
☐ NO

Dates of treatment:
_____

_____

For current episode?
_____

For prior episodes?
_____

Did it help?
☐ Yes
☐ No
☐ Made it worse

CHIROPRACTIC

☐ YES
☐ NO

Dates of treatment:
_____
_____

For current episode?
_____

For prior episodes?
_____

Did it help?
☐ Yes
☐ No
☐ Made it worse

HOME EXERCISE PROGRAM

Do you currently do a regular exercise or stretching program for your pain?
_____

MEDICATIONS

Have you or are you currently taking anything for pain?

☐ YES
☐ NO

Please circle any of the following that you have tried:

Anti-inflammatories:

(Aleve, Aspirin, Ibuprofen, Meloxicam, Diclofenac)

Pain Medications:

(Hydrocodone, Oxycodone, Tramadol, Morphine, Methadone)

Muscle Relaxants:

(Cyclobenzaprine, Tizanidine)

Nerve Medications:

(Gabapentin, Cymbalta, Lyrica)

Other:
_____
_____

PROVIDERS

Have you seen other physicians for this problem?
_____

When?_____

INITIAL PAIN EVALUATION FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ____/____/____ FAMILY DOCTOR _____

NAME_____ DATE OF BIRTH ____ /____ /____

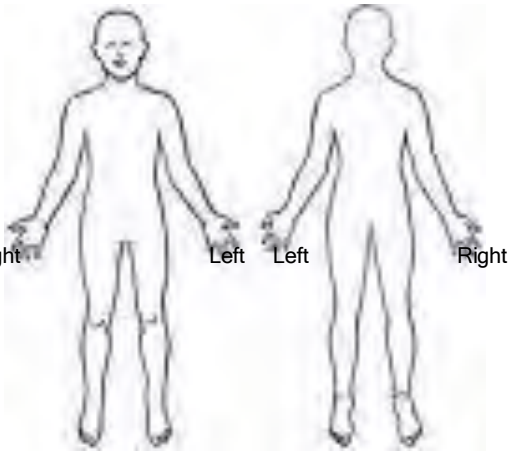
CHIEF COMPLAINT - What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

Were you referred to us by another health care professional? (If yes please state name)_____

Please draw area of pain.
If the pain radiates, describe this as well:



Please mark all that apply to you now or that you have had in the past!

Eyes	**Y**	**N**	**Gastrointestinal**	**Y**	**N**	**Endocrine**	**Y**	**N**
Blurred Vision			Blood in vomit			Weight Loss		
Double Vision			Abdominal Pain			Weight Gain		
						Excessive Thirst		
HENT	**Y**	**N**	**Integumentary**	**Y**	**N**			
Headaches			Rash			**Psychiatric**	**Y**	**N**
Lightheadedness			Hair growth change			Anxiety		
Neck Pain						Depression		
			Neurological	**Y**	**N**			
Cardiovascular	**Y**	**N**	Sciatica			**Hematological**	**Y**	**N**
Chest Pain/ Angina			Arm Numbness/Tingling			Bleeding Tendencies		
Leg Pain While Walking			Leg Numbness/Tingling			DVT		
Pacemaker								
			Musculoskeletal	**Y**	**N**	**Allergic**	**Y**	**N**
Respiratory	**Y**	**N**	Neck Pain			Food Allergies		
Shortness of Breath			Arm Pain			Contrast Dye Allergy		
Cough			Back Pain			Iodine Allergy		
			Leg / Foot Pain					
						Female	**Y**	**N**
						Are You Pregnant?		

PAST MEDICAL HISTORY:

List all chronic illnesses/conditions: (Example: diabetes, heart disease, high blood pressure, etc.)

_____ _____ _____
_____ _____ _____
_____ _____ _____

List any past surgeries
Surgery Approximate Date
_____
_____
_____
_____
_____
_____

Are you on any medications? Y N (If yes, list all or provide a list & dates tried)
_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have any medication allergies? ☐ Yes ☐ No (If yes, list all or provide a list)
_____ _____ _____
_____ _____ _____
_____ _____ _____

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No
If yes, how much? _____

Do you drink alcohol? ☐ Yes ☐ No
If yes, how much? _____

Occupation/Employer: _____

Have you had any complications with bleeding? ☐ Yes ☐ No

Do you take a blood thinner, such as Coumadin, Plavix, Heparin, Aspirin, etc?
If so, what? _____

Family History:	*Serious Health Problems / Important* **Notes:**
Mother If deceased, at what age? _____	
Father If deceased, at what age? _____	

The information given in the Patient History form is accurate to the best of my knowledge.

Signature_____ Date _____