

Physician Signature: _____

Date: _____

Ortho**Neuro**

Name: _____ Date: _____ Age: _____

SS#: _____ Sex: Male _____ Female _____ DOB: _____

Referring Physician: _____

Referring Physician Address: _____

Mark the areas on the corresponding figures where you feel the described sensations.
Mark areas of radiation using an arrow. Include all affected areas.

	Dull Aching
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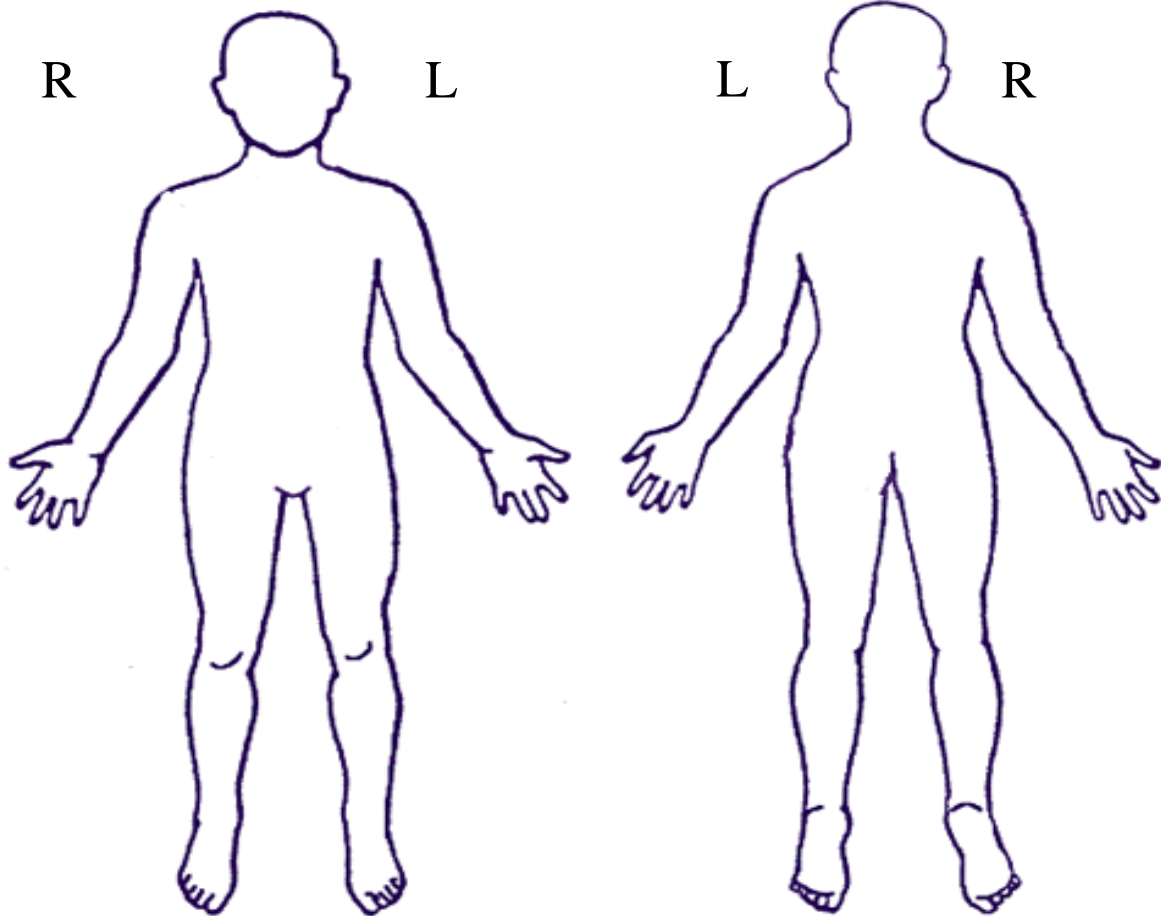
	Burning
--	---------

	Numbness
--	----------

	Stabbing
--	----------

	Pin and Needles
--	--------------------

	Muscular Cramp
--	-------------------



Please circle or mark with an X on this line the level or intensity of pain, discomfort that you are currently experiencing.

_____ / _____ / _____
 no pain pain as bad as it could be

A.) What is the nature of today's visit? _____

Date accident or symptoms occurred. _____ Is this work related? Yes No

Is this the first time you have had this problem? Yes No

Give a detailed description of the event: _____

List any physicians you have seen for this problem: _____

Do you have trouble with (please circle)

Weakness Bladder Bowels Walking (how far) _____

Bending Twisting Dressing Lifting (how much) _____

Sitting (how long) _____ Car Rides _____

Sleep Morning Stiffness Changes in Weather

Stairs (how many flights) _____ Lying Down Numbness Fever

Chills Rashes Joint Swelling Other _____

Currently (today) how severe is the pain in your spine (neck or back)?

_____ no pain _____ intolerable

Currently (today) how severe is the pain in your limb (arms or legs)?

_____ no pain _____ intolerable

How often does the pain interrupt your sleep? ___ not at all ___ occasionally

___ half of the time ___ often ___ always ___ never sleep well

Is your pain (please circle) CONSTANT INTERMITTENT VARIES

B.) Occupation _____ Date last worked _____

How long have you been with this job? _____

Exercise Habits: (please describe) _____

Hobbies: _____

C.) Treatment up to date: (please circle)

Osteopathic Chiropractic Physical Therapy Injections Bracing Traction Surgeries

Describe: _____

D.) PLEASE LIST BELOW

Allergies to medication: _____

CURRENT medications for this problem (name, dose, frequency)

Other CURRENT medications: (name, dose, frequency)

Prescription and non-prescription medications taken in the PAST (indicate if it is for the current problem): _____

Other medical problems:

- | | |
|--------------------------------|---|
| _____ Heart Disease | _____ Sinusitis |
| _____ Lung Disease | _____ Ear Infection |
| _____ Cholesterol | _____ Arthritis (osteo/rheumatoid) |
| _____ Dental Disease | _____ Ulcer/Stomach Disease |
| _____ High Blood Pressure | _____ Skin Disorder |
| _____ Brain Tumor | _____ Sore Throat/Tonsillitis |
| _____ Encephalitis/ Meningitis | _____ Mononucleosis |
| _____ Headaches | _____ Lumps/Cysts |
| | _____ Deep venous Thrombosis/
Thrombophlebitis |
| _____ Thyroid problems | _____ Bleeding Disorders/Anemia |
| _____ Panic Attacks | _____ Hepatitis A or B / Liver Disease |
| _____ Mental Illness | _____ Aneurysm |
| _____ Depression | _____ Bronchitis/Asthma |
| _____ Cancer | _____ Sleep Disorder |
| _____ Stroke | _____ Seizure/Epilepsy |
| _____ Diabetes/Hypoglycemia | _____ Tuberculosis |
| _____ Glaucoma | _____ Other: explain _____ |
| _____ Kidney Disease | _____ Other: explain _____ |

Surgeries and hospitalizations (where, hospital/city, type of surgery/treatment):

E.) Check any that apply

_____ Single _____ Married _____ Divorced _____ Widowed

How many children do you have and their ages: _____

How much do you smoke per day? _____

How many years have you smoked? _____

Do you use smokeless tobacco? _____ Yes _____ No

Please indicate how much alcohol you consume:

_____ Beers per week

_____ Glasses of wine per week

_____ ounces (drinks) of liquor per week

Have you in the past or do you use recreational drugs? _____ Yes _____ No

Last year of school completed? _____

What is your support system? _____

F.) Indicate who among your **close relatives** may have any of the following ailments?

Heart Disease _____ Seizure or Epilepsy _____

Cancer _____ Brain Tumor _____

Lung Disease _____ Headaches _____

High Blood Pressure _____ Thyroid _____

Cholesterol _____ Arthritis _____

Stroke _____ Muscular Disease _____

Ulcer _____ Spine Problems _____

Diabetes _____ Panic Attacks _____

Hypoglycemia _____ Mental Illness _____

G.) Which test have you had in the past? (where, when and results)

MRI: _____

EEG: _____

Disc Injections: _____

X-Rays: _____

Bone Scan: _____

Cat Scan: _____

Myelogram: _____

EMG / Nerve Conduction Study: _____

H.) What is your height? _____ Weight? _____

I.) Review of Systems

Yes

No

Do you have a fever?

Do you have a skin rash?

Have you gained or lost weight in the last six months?

How much _____

Are you intolerant of heat or cold?

Do you sweat heavily at night?

Any skin lumps, cysts, or lesions?

Any changes in skin, hair, nail or teeth?

Do you have eye pain, redness, or inflammation?

Has your vision been blurred or doubled?

Have you ever lost vision in one or both eyes?

Do you experience dizziness or lightheadedness?

Have you ever fainted, passed out or blacked out?

Do you have difficulties with balance or unsteadiness?

Do you have ear pain or fullness?

Do you have hearing difficulties or ringing in your ears?

Does your face become numb or lose sensations?

Is your sense of smell or taste disturbed?

Are your teeth sensitive to cold, hot, or other?

Do you have sinus discharge, blood or mucus?

Do you have chest pain?

Does your heart race or skip beats?

Do you become short or breath?

Do your feet or ankles swell?

Do you cough up phlegm or blood?

Do you have a persistent cough or wheeze?

Any pain or discomfort in your abdomen?

Has your appetite changed?

Have you had nausea or vomiting?

Do you suffer from constipation, diarrhea or excess gas?

Have there been any changes in your bowel movements?

Have you been jaundiced?

Do you have burning or pain with urination?

Do you have to get up often at night to urinate?

Do you experience weakness of the arms or legs?

Any numbness or tingling of the arms or legs?

Do you have headaches or facial pain?

Do you have neck or back pain?

Do you have muscle pain or swelling?

Do you have joint pain or swelling?

Do you have difficulty with concentration or memory?

Do you often feel depressed?

Do you often feel anxious or nervous?

Do you often feel tired or sleepy?

Do you have difficulty falling asleep or staying asleep?

Do you have suicidal thoughts?

Sign Here _____

All Finished! Thank You

PHYSICAL EXAM

RR: _____ HR: _____ BP: _____

General: _____

Position / Deformities: _____

CV: Pulse, Temperature, Edema: _____

Gait: REG / Heel / Toes: _____

ROM: Ext _____

Flex _____

Lat Bend _____

Rot _____

Spasm / Tenderness / TP: _____

Shoulder / Hip: ROM, Provocation, Instability _____

Mental Status: _____

CN: _____

MSR: Knee (L3-4)
Med Ham (L5)
Ankle (S1)

Biceps (C5)
Brachioradialis (C6)
Triceps (C7)

Babinski: R _____ L _____ Hoffman: R _____ L _____

Tone: Flaccid, Cogwheel, spastic, NL): _____

Clonus: _____

Motor: Atrophy

Gastroc (S1)
EHL (L5)
Ankle inv/evert (L4/S1)
Quad (L3-4)

Biceps (C5)
ECRL+B (C6)
Triceps (C7)
Finger Flex (C8)
Finger abd (T1)

Sensory: Thigh (L3)
Medial Calf (L4)
First Dorsal Webspace (L5)
Lat Calf (S1)

Lat Shoulder (C5)
Thumb (C6)
Middle Finger (C7)
Little Finger (C8)
Medial Elbow (T1)

SLR: Sitting/Supine: Hamstrings: _____

Spurling's: _____

Tinel's: _____ Phalen's: _____

Fabere's: _____ Thigh Trust: _____

Waddell's: Overreaction
Distraction SLR
Simulation: Axial, Rotation
Regional Weakness, Sensory