

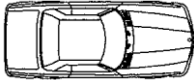
Interventional Initial History



Name: _____ Date: ____/____/____

DOB: ____/____/____ Please provide the following medical information to the best of your ability.

1. Date of your accident/injury? _____
(If your visit is not related to an accident, please skip to (C) below)

<p>A. Motor Vehicle Accident: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Seat Belt <input type="checkbox"/> Air Bag Deployed <input type="checkbox"/></p> <p>Indicate site of impact: "P" = Primary "S" = Secondary</p> <div style="text-align: center;">  </div> <p>Did you hit your head? Yes <input type="checkbox"/> No <input type="checkbox"/> Any loss of consciousness? Yes <input type="checkbox"/> No <input type="checkbox"/> Memory problems? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>B. Work Related Injury: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Has this injury been accepted as a Worker's Compensation claim? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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C. Describe your main reasons for this visit (i.e. chief complaint):

D. Describe your accident/injury or history of problem in detail.

2. Have your symptoms gotten.... Worse Better Same (check only one)

3. Your present pain is.... Constant Intermittent Worse in the... A.M. P.M.

4. What activities increase your pain?
 Sitting Standing Walking Lifting Housework
 Coughing/Sneezing Lying flat on back Lying flat on stomach

5. What activities decrease your pain?
 Sitting Standing Walking Lying flat on back Lying flat on side with knees bent

6. Are you: Right-Handed Left-Handed

7. Do you have any pain going down your arm or leg... No Yes (if "yes" circle the area involved)
 Right Arm Left Arm Right Leg Left Leg

Do you have any numbness/tingling down your arm or leg... No Yes (if "yes" circle the area involved)
 Right Arm Left Arm Right Leg Left Leg

Do you have any weakness of your arm or leg... No Yes (if "yes" circle the area involved)
 Right Arm Left Arm Right Leg Left Leg

8. Do you have difficulty sleeping because of pain? Yes No

9. Have any other physicians evaluated you for this problem? Yes No
 If yes, who/when? _____

10. Have any tests (x-rays, CT scan, MRI) been done to evaluate this problem? Yes No
 If yes, please describe and give the facility name: _____

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Initial History (cont'd) Name: _____ Date: ____/____/____

11. What treatments have you received? Please describe (ex: PT, Chiro, Surgery)

_____ Made Better Worse No Change
 _____ Made Better Worse No Change
 _____ Made Better Worse No Change

12. Have you had any previous accident, injury or problems with your neck, back, shoulders, or knees?

Yes No If yes, please describe where and when: _____

13. Pain Medications that you are taking now:

List all your pain medicines including any that are over-the-counter such as Tylenol, Aleve, etc.

Name	Does it help?	Side effects?
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	

14. Pain Medications that you have taken in the past:

Name	Did it help?	Side effects?
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	

15. All other regular medicines if any: (ex: for blood pressure, diabetes, ulcers, blood thinners)

(Please include any over-the-counter drugs, eye drops, vitamins, etc.)

Name	For how long?	Side effects?

16. Drug allergies:

Aspirin Sulfa drugs Novocain/Lidocaine Iodine Dye Penicillin Shellfish Latex

Other: (write medicine name and reaction)

17. Past Medical History - Please check the "Yes" or "No" box if you have any of the following illnesses; for "Yes" answers, please explain.

Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Thyroid problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Hypertension (high blood pressure)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Allergy problems/Therapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Kidney/Bladder/Prostate problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
High Cholesterol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Neurological problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Respiratory problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Addiction or Substance Abuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Stomach/Intestinal problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Mental Health/Psychiatric	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Bleeding Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Other medical diagnosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

18. Past Surgical History: (Please list all surgeries)

Type of Surgery	When & Name of Surgeon



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Initial History(cont'd) Name: _____ Date ____/____/____

19. Review of systems:

a. Please check the "Yes" or "No" box if you have any of the following symptoms.
 b. Check the "Current" box if this symptom relates to the reason for your visit today.

		<u>Yes</u>	<u>No</u>	<u>Current</u>		<u>Yes</u>	<u>No</u>	<u>Current</u>
GENERAL	Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss or Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Daytime Sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGY	Environmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing fits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEURO	Passing out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES	Eye pain/pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY	Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coughing Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Wake short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GASTRO - INTESTINAL	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bowel Irregularity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GENITOURINARY	Frequent Urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Loss of bladder control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is there a chance you are pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEME/LYMPH	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweating at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE	Feel warmer than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel cooler than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MUSCULOSKEL	Joint pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Muscle ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Loss of mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
DERMATOLOGIC	Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin or Hair changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MENTAL HEALTH	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mood changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Anxiety/panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

20. Family History: Please check the "Yes" or "No" box if any relatives have/had any of the following illnesses. If yes, please indicate which relative(s) have/had the problem.

	<u>Yes</u>	<u>No</u>	
Back problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems/murmurs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	_____



Reviewed By (Initials) _____

Initial History(cont'd) Name: _____ Date ____/____/____

- 21. Are you currently: Single Married Widowed Divorced Separated
- 22. Where do you live? -Apartment 2-Story House -Ranch-Style House
- 23. How many children do you have? _____ Ages _____ How many live with you _____
- 24. Do you smoke cigarettes? Yes No Packs per day: _____
- 25. Do you drink alcoholic beverages? Yes No How much each day? _____
- 26. Do you take or have you ever used any street drugs(ex-marijuana, cocaine, etc.)? Yes No
- 27. Are you working? Yes No Full-Time Part-Time
When did you last work? Date: _____ **Is there light duty available at work?** Yes No
- 28. Occupation and job duties: (ex: sitting at a computer, lifting, bending, twisting, etc.)

- 29. If you are not working now, do you see yourself.... (check all that apply)
 returning to the same job modifying your work
 changing jobs – same employer changing jobs – different employer
 retraining or returning to school applying for early retirement or long-term disability benefits
- 30. Do you enjoy your work? Yes No
- 31. Do you like your co-workers? Yes No
- 32. What hobbies or activities (work, sports, and hobbies) do you hope to return? _____

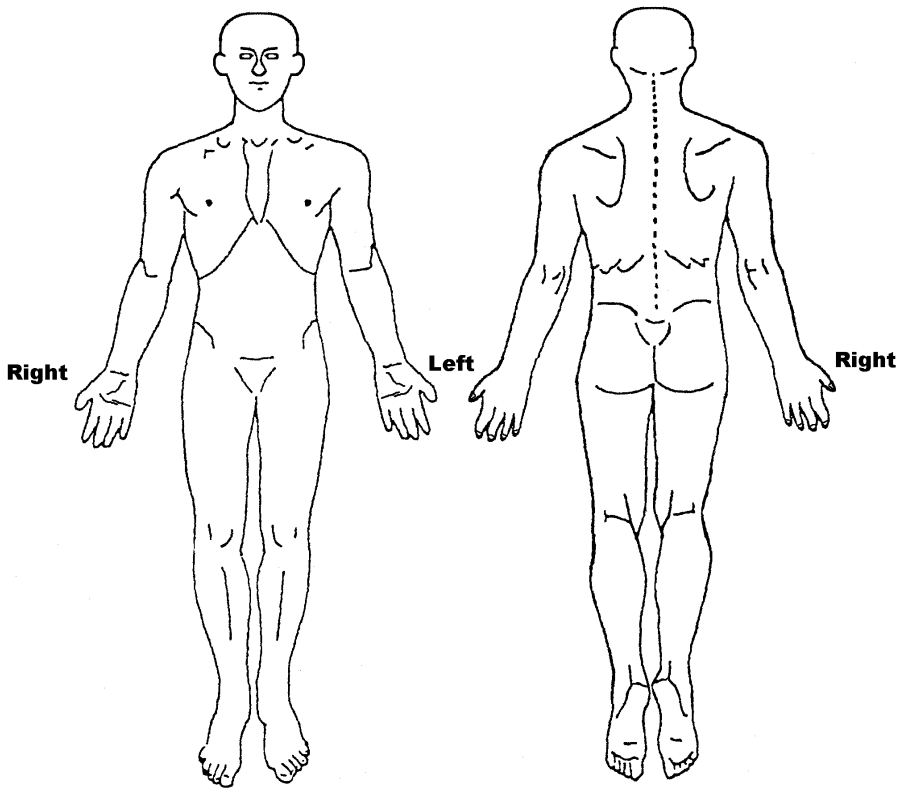
PAIN DRAWING

INSTRUCTIONS:

Mark these drawings according to where you hurt (if the back of your neck hurts, mark the drawing on the back of the neck, etc.). If you feel any of the following symptoms, please indicate which sensations you feel by placing the marks shown below.

KEY

XXX for Burning	/// for Stabbing	+++ Aching	OOO Pins & Needles	=== Numbness
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PAIN LEVEL: (Circle one)

0 (no pain) 1 (tolerate pain without medication) 2 3 4 (requires medication) 5 6 7 8 (go to ER) 9 (severe pain) 10 (admit to hospital for pain control)



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 200 Banning Street, Suite-350, Dover, DE 19904 ~ 302-730-8848
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Reviewed by (initials) _____

See attached dictation