

PHYSICAL EXAMINATION FORM

PATIENT INFORMATION

Name: _____ Date: _____
Address: _____ Birthdate: _____
City: _____ Age: _____ Sex: _____
Home Phone: (____) _____ Work Phone: (____) _____
In Case of Emergency Notify:
Name: _____ Relationship: _____ Phone Number (____) _____

HISTORY

Marital Status: Married ___ Single ___ Widowed ___ Divorced ___
Do You Smoke? Yes ___ No ___ If Yes, How Much: _____
Do You Drink Alcoholic Beverages? Yes ___ No ___ How Much? _____
Have you ever received treatment for any type of addiction? Yes ___ No ___
If Yes, Describe: _____
Are you pregnant or plan to become pregnant? Yes ___ No ___
Do you exercise or have hobbies? _____
Does your pain interfere with your exercise of hobbies? Yes ___ No ___
If Yes, How? _____
Name of Employer: _____
Occupation: What work do you do and what does your work involve?

How many hours do you work per week? _____
In the past month have you missed work due to pain? _____

PAIN HISTORY

In your own words describe what your pain is like, how it feels and is it constant or does it come and go?

How long have you had this problem? _____

PREVIOUS TREATMENT FOR PAIN

Check One	Yes	No	Physician	Date
Nerve Blocks/Pain Management	___	___	_____	_____
Surgery	___	___	_____	_____
Tens Unit	___	___	_____	_____
Occupational/Physical Therapy	___	___	_____	_____
Biofeedback	___	___	_____	_____
Hypnosis	___	___	_____	_____
Counseling	___	___	_____	_____
Chiropractor	___	___	_____	_____

PAIN HISTORY CONTINUED

Which of the following tests have you had to evaluate your pain problem within the past 12 months?

Test	Date	Facility	Physician	Normal/Abnormal
X-Ray	_____	_____	_____	_____
CT Scan	_____	_____	_____	_____
MRI	_____	_____	_____	_____
Laboratory	_____	_____	_____	_____
EMG	_____	_____	_____	_____
Myelogram	_____	_____	_____	_____
Rectal/Hemoccult	_____	_____	_____	_____
Bone Scan	_____	_____	_____	_____

MEDICAL HISTORY

Weight: _____ Height: _____

Have you or do you have any of the following conditions?

- | | | | |
|--------------------------|-------------|-----------------------|-------------|
| ___ Diabetes | Date: _____ | ___ Emphysema | Date: _____ |
| ___ Asthema | Date: _____ | ___ Allergies | Date: _____ |
| ___ Cancer | Date: _____ | ___ Ulcer | Date: _____ |
| ___ Arthritis | Date: _____ | ___ Kidney Problems | Date: _____ |
| ___ High Blood Pressure | Date: _____ | ___ Bleeding Disorder | Date: _____ |
| ___ Heart Problems | Date: _____ | ___ Seizure Disorder | Date: _____ |
| ___ Psychological Issues | Date: _____ | ___ Anxiety Disorder | Date: _____ |
| ___ Other | Date: _____ | ___ Other | Date: _____ |

Comments: _____

List any surgeries you have had:

Type of Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications? If so, which ones? _____

Are you allergic to latex products? Yes ___ No ___
Are you taking blood thinning medication? Yes ___ No ___
If so, list: _____

MEDICAL HISTORY CONTINUED**Current Medications:** (medication that you are currently taking)

Medication	Why Prescribed	Dosage	Effectiveness
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Litigation: If your pain is due to an accident, is litigation (Legal Suit) or an insurance settlement pending? Do you have plans to pursue a legal or insurance settlement in the future? If yes to either question, please describe:

RELEASE OF RECORDS

I give permission to the physician to release copies, diagnostic procedures, etc. that may be beneficial in the understanding and treatment of my current condition.

Patient Name: _____ Date: _____

Patient Signature: _____

PHYSICIAN CONDUCTING PHYSICAL EXAMINATION

Physician Name: _____

Date: _____

Physician Signature: _____

Medical Facility Name: _____

Address: _____

Phone Number: _____