NAME: ____ **DATE**: ______________

- Are you here for a second opinion? ________ YES _________ NO

- Date of Injury: ______________________________ Date Symptoms Began: ________________________

- Were you injured on the job? ________ YES _________ NO

- If yes, how did injury happen? ____

- Where? ____ What time? ______________

- Have you been treated before for this injury? ________ YES _________ NO

- Were x-rays or tests done? ________ YES _________ NO

- Did you bring them or a report with you? ________ YES _________ NO

- Able to continue activity or work? ________ YES _________ NO

- If unable to work, please give date of last day worked: _____________________________

- Location of pain (i.e., shoulder, knee, etc.): ___________________________ Circle: Left Right

- Diagnosis given: _________________________________ Treatment given: ___________________________

- **Was surgery performed?** ________ YES _________ NO
(If so, please obtain operative report or notify the receptionist so she may obtain a copy for our records.)

- Date of surgery: ____________________________ Surgery performed: ______________________________

- List of all previous surgeries (name and approximate date)

1. ____ 2. _______________________________

3. ____ 4. _______________________________

List any medications you are currently taking and how you take them.

1. ____ 2. _______________________________

3. ____ 4. _______________________________

- Drug allergies? ________ YES _________ NO Height ______________ Weight ______________

- **Have you ever had:** (Please circle **Y** for yes and **N** for no)

Heart trouble, attack, angina	**Y**	**N**	High blood pressure	**Y**	**N**
Abnormal EKG	**Y**	**N**	Stroke	**Y**	**N**
Emphysema, other lung or breathing problems	**Y**	**N**	Jaundice, hepatitis, mono	**Y**	**N**
Epilepsy or seizures	**Y**	**N**	Blood disease, (Anemia, etc.)	**Y**	**N**
Glaucoma	**Y**	**N**	Facial bone fractures	**Y**	**N**
Blood thinners	**Y**	**N**	Paralysis	**Y**	**N**
Kidney disease	**Y**	**N**	Diabetes	**Y**	**N**
Neck or back trouble	**Y**	**N**	Cancer	**Y**	**N**
Muscle weakness	**Y**	**N**	Positive HIV/Aids test	**Y**	**N**
Blood vessel disease	**Y**	**N**	Ulcers	**Y**	**N**
Arthritis	**Y**	**N**	Thyroid dx	**Y**	**N**
Do you smoke? Packs/day__________________	**Y**	**N**	Could you be pregnant?	**Y**	**N**

Signature: ____