

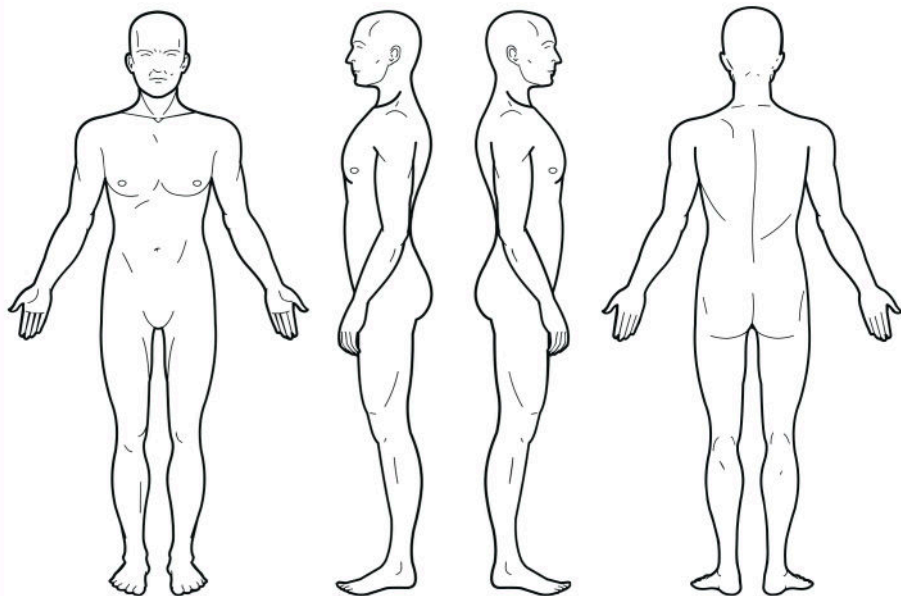


PATIENT NAME: _____ Age _____ DOB: _____

OCCUPATION: _____ DATE: _____

PAIN LOCATION

Circle area of WORST pain. Mark other pain areas with "X."



WHAT BRINGS YOU IN TODAY?

WHEN DID PAIN BEGIN?

SEVERITY OF YOUR PAIN

On a scale of 1-10 (0=no pain; 10=the worst)

Level currently? _____ /10
Level at best? _____ /10
Level at worst? _____ /10

REGARDING YOUR PAIN, CHECK ALL THAT APPLY:

HOW DID THE PAIN BEGIN?

- ☐ Work related accident
- ☐ Motor vehicle accident
- ☐ Fall
- ☐ Post surgical
- ☐ Post interventional procedure
- ☐ Other _____

DESCRIBE YOUR PAIN

- ☐ Sharp
- ☐ Stabbing
- ☐ Shooting
- ☐ Burning
- ☐ Other _____
- ☐ Dull
- ☐ Aching
- ☐ Spasm
- ☐ Tight

DOES THE PAIN AFFECT YOUR:

- ☐ General activity
- ☐ Mood
- ☐ Walking ability
- ☐ Work routine
- ☐ Sleep
- ☐ Enjoyment of life
- ☐ Concentration
- ☐ Appetite
- ☐ Relationships
- ☐ Other _____

WHAT MAKES THE PAIN WORSE?

- ☐ Lifting
- ☐ Bending
- ☐ Twisting
- ☐ Sitting
- ☐ Other _____
- ☐ Standing
- ☐ Driving
- ☐ Lying down
- ☐ Walking

WHAT MAKES THE PAIN BETTER?

- ☐ Exercise
- ☐ Sitting
- ☐ Standing
- ☐ Lying down
- ☐ Other _____
- ☐ Medication
- ☐ Ice
- ☐ Heat
- ☐ Nothing

What services are you interested in? Injection Therapy, OMT, Nutrition, Stress Management, etc.

Have you ever had a severe accident/injury? If so, when? Please explain. _____

How did you hear about Life in Balance/Referral? _____

PATIENT NAME: _____ DOB: _____

DATE: _____

PREVIOUS TREATMENTS

HAVE YOU BEEN EVALUATED BY:

- ☐ Osteopathic Physician
- ☐ Orthopedic Surgeon
- ☐ Spine Surgeon
- ☐ Neurosurgeon
- ☐ Physical Medicine (PMR)
- ☐ Neurologist
- ☐ Psychiatrist/Psychologist
- ☐ Physical Therapist (PT)
- ☐ Chiropractor

ORTHOPEDIC PROCEDURES/ INTERVENTIONS

- ☐ Cervical fusion
- ☐ Vertebroplasty
- ☐ Kyphoplasty
- ☐ Lumbar laminectomy w/wo fusion
- ☐ Shoulder/rotator cuff repair/tenodesis
- ☐ Carpal tunnel release
- ☐ Total hip/knee arthroplasty (THA/TKA)
- ☐ Radio-frequency ablation (RFA)
- ☐ Other: _____

OTHER SURGICAL HISTORY

- ☐ Tonsillectomy
- ☐ Thyroidectomy
- ☐ Gallbladder removal
- ☐ Appendectomy
- ☐ Hernia repair
- ☐ Bypass (CABG)
- ☐ Angioplasty w/wo stent
- ☐ Pacemaker/defibrillator
- ☐ C-Section
- ☐ Other: _____

HAVE YOU EVER HAD OR BEEN

DIAGNOSED WITH:

- ☐ Cervical (neck) trauma Known
- ☐ coagulation defect
- ☐ Inflammatory spondylopathy
- ☐ Osteoporosis
- ☐ Aortic aneurysm/dissection

PREVIOUS INJECTION THERAPY

- ☐ Platelet Rich Plasma (PRP)
- ☐ Perineural Injection Treatment (PIT)
- ☐ Prolotherapy
- ☐ Epidural steroid INJ
- ☐ Facet INJ (cervical/thoracic/lumbar)
- ☐ Sacroiliac joint INJ Trigger point INJ
- ☐ Shoulder/hip/knee INJ Steroid INJ
- ☐ Steroid INJ
- ☐ Synvisc/Monovis INJ
- ☐ Synvisc/Monovis INJ
- ☐ Tenotomy/dry needling
- ☐ Other

ANYTHING ELSE:

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

CONSTITUTIONAL (CIRCLE WHICH)

- ☐ Fevers/chills/fatigue/night sweats
- ☐ Loss of appetite
- ☐ Unintentional weight loss/gain
- ☐ Insomnia

EYES/EARS/NOSE/THROAT

- ☐ Headaches/visual disturbances
- ☐ Sore throat
- ☐ Difficulty swallowing

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Difficulty breathing when you lie down
- ☐ Difficulty breathing that wakes you

GASTROINTESTINAL

- ☐ Nausea/vomiting/diarrhea
- ☐ Abdominal pain/constipation
- ☐ Bloody stools

RESPIRATORY

- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Cough
- ☐ Coughing up blood

GENITOURINARY

- ☐ Urinating at night
- ☐ Urinating too much
- ☐ Incontinence

MUSCULOSKELETAL

- ☐ Loss of bowel or bladder function
- ☐ Chronic low back pain
- ☐ Joint pain

NEUROLOGIC

- ☐ Issues with balance
- ☐ Weakness
- ☐ Numbness or tingling
- ☐ Pins & needles

HEMATOLOGIC/ENDOCRINE

- ☐ Excessive bleeding
- ☐ Bruising

PSYCHIATRIC

- ☐ Depression
- ☐ Anxiety
- ☐ Difficulty concentrating
- ☐ Thoughts of self-harm
- ☐ Thoughts of violence
- ☐ PTSD

FEMALES

- ☐ Pelvic pain
- ☐ Discharge
- ☐ Pain with intercourse
- ☐ Abnormal periods
- ☐ Heavy bleeding
- ☐ Abnormal uterine bleeding

PATIENT NAME: _____ DOB: _____

MEDICATION

"C" = Currently taking; "T" = Tried & failed in the past

PAIN RELIEVER/NSAIDs

- ___ Tylenol (Acetaminophen)
- ___ Motrin (Ibuprofen)
- ___ Aleve (Naproxen)
- ___ Mobic (Meloxicam)
- ___ Celebrex (Celecoxib)
- ___ Voltaren Gel (Diclofenac)
- ___ Other _____

MUSCLE RELAXER:

- ___ Flexeril (Cyclobenzaprine)
- ___ Robaxin (Methocarbamol)
- ___ Norflex (Orphenadrine)
- ___ Zanaflex (Tizanidine)
- ___ Soma (Carisoprodol)
- ___ Baclofen

NERVE MEDICINE:

- ___ Neurotin (Gabapentin)
- ___ Lyrica (Pregabalin)

BENZODIAZEPINES:

- ___ Valium (Diazepam)
- ___ Ativan (Lorazepam)
- ___ Klonopin (Clonazepam)

ANTI-DEPRESSANTS (SSRI/SNRI/TCA):

- ___ Prozac (Fluoxetine)
- ___ Effexor (Venlafaxine)
- ___ Celexa (Citalopram)
- ___ Lexapro (Escitalopram)
- ___ Elavil (Amitriptyline)
- ___ Cymbalta (Duloxetine)
- ___ Nortriptyline

SLEEP MEDICINE:

- ___ Ambien (Zolpidem)
- ___ Lunesta (Eszopiclone)
- ___ Restoril (Temazepam)
- ___ Rozarem
- ___ Melatonin
- ___ Trazodone

NARCOTICS/OPIATES/OPIOIDS:

- ___ Duragesic (Fentanyl)
- ___ Dilaudid (Hydromorphone)
- ___ Ultram (Tramadol)
- ___ Methadone
- ___ Norco/Lortab (Hydrocodone)
- ___ Oxycontin/Percocet (Oxycodone)
- ___ Suboxone
- ___ Low Dose Naltrexone

PREFERRED PHARMACY LOCATION

OFFICE STAFF: GR

FOOD OR DRUG ALLERGIES:

LIST OTHER MEDS (WITH STRENGTH) INC. OVER-THE-COUNTER, SUPPLEMENTS, VITAMINS, ETC.

MEDICAL HISTORY

☐ High blood pressure

S M F BR SI

Diabetes

S M F BR SI

☐ Heart Disease

S M F BR SI

Thyroid disease

S M F BR SI

☐ Kidney disease

S M F BR SI

Liver disease/hepatitis

S M F BR SI

Lung disease/COPD

☐ S M F BR SI

Cancer Where? _____

S M F BR SI

Autoimmune Condition

☐ S M F BR SI

Spine Problems

S M F BR SI

Other

☐ S M F BR SI

KEY

S Self
M Mother
F Father
BR Brother
SI Sister

SOCIAL HISTORY

Tobacco use: ☐ Yes ☐ No ☐ Previously Used

How much? _____ Quit date? _____

THC/Cannabis use: Yes No Previously Used

How much? _____ How often? _____

Alcohol use: ☐ Yes ☐ No

Drinks per week/month? _____

Illicit drug use: Yes No Previously Used

What? _____ How much? _____

Caffeine use: How much per day? _____

Exercise:

Type _____ How often? _____

Fruits/Vegetables Intake: Servings per day? _____

Water Intake: Ounces per day? _____

WHEN WE OBTAIN PAYMENT FOR SERVICES, MAY WE KEEP YOUR CREDIT CARD ON FILE ☐ YES ☐ NO

DR. GRUBER MAY BE USING DICTATION IN HER EVALUATIONS/SESSIONS. IS THIS OKAY? ☐ YES ☐ NO

PATIENT SIGNATURE

DATE

PHYSICIAN REVIEWED

DATE