Full Name *Date of Birth*

Medications:

List any medications that you are currently taking including all pain medications.

☐ None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Primary Pharmacy

Pharmacy Name/Address/City: _____

Allergies:

Select any allergies from the list: ☐ No known allergies

- ☐ Accupril (Quinapril)
- ☐ Acetaminophen
- ☐ Acyclovir
- ☐ Advil (Ibuprofen)
- ☐ Altace (Ramipril)
- ☐ Ampicillin
- ☐ Amaryl (Glimepiride)
- ☐ Augmentin (Amoxicillin)
- ☐ Aspirin
- ☐ Bactrim
- ☐ Ceclor (Cefaclor)
- ☐ Celebrex
- ☐ Cephalosporins
- ☐ Cipro (Ciprofloxacin)
- ☐ Compazine (Promazine)
- ☐ Contrast Media (Ioversol)
- ☐ Codeine
- ☐ Coumadin
- ☐ Darvon
- ☐ Demerol
- ☐ Depakote
- ☐ Doxycycline
- ☐ Egg
- ☐ Erythromycin
- ☐ Famotidine
- ☐ Flagyl
- ☐ Floxin
- ☐ Gabapentin
- ☐ Glucotrol(Glipizide)
- ☐ Heparin
- ☐ Hydrocodone
- ☐ Ibuprofen
- ☐ Inderal (Propranolol)
- ☐ Indocin (Indomethacin)
- ☐ Insulin
- ☐ Iodine or Shellfish
- ☐ IVP Dye
- ☐ Keflex (Cephalexin)
- ☐ Klonopin
- ☐ Lasix (Furosemide)
- ☐ Latex
- ☐ Levofloxacin
- ☐ Levaquin
- ☐ Lidocaine
- ☐ Lipitor
- ☐ Lisinopril
- ☐ Lodine
- ☐ Lopressor (Metoprolol)
- ☐ Morphine
- ☐ Motrin (Ibuprofen)
- ☐ Naprosyn (Naproxen)
- ☐ Niacin
- ☐ Oxycodone
- ☐ Peanut
- ☐ Penicillin
- ☐ Percocet (Oxycodone)
- ☐ Plavix
- ☐ Prednisone
- ☐ Prevacid
- ☐ Prilosec
- ☐ Ranitidine
- ☐ Sulfa
- ☐ Tagamet (Cimetidine)
- ☐ Tetanus Toxoid
- ☐ Tetracycline
- ☐ Tramadol
- ☐ Valium (Diazepam)
- ☐ Vancomycin
- ☐ Zithromax
- ☐ Zocor (Simvastatin)
- ☐ Zyloprim (Allopurinol)

_____

_____

_____

_____

Medical History: Select all current and past medical conditions and include the year of diagnosis

- ☐ None
- ☐ Abnormal Heart Rhythm _____
- ☐ Anemia
- ☐ Asthma _____
- ☐ Cancer _____
- ☐ Liver Disease _____
- ☐ Hypertension _____
- ☐ Inflammatory Bowel _____
- ☐ Depression _____
- ☐ Diabetes
- ☐ Endometriosis _____
- ☐ Ovarian Cyst _____
- ☐ Heart Attack _____
- ☐ Osteoarthritis _____
- ☐ Tuberculosis _____
- ☐ Bronchitis _____
- ☐ Emphysema _____
- ☐ Hepatitis _____
- ☐ Irritable Bowel _____
- ☐ Stomach Ulcer _____
- ☐ Kidney Failure _____
- ☐ Anesthetic Complications _____
- ☐ Anorexia _____
- ☐ Bulimia _____
- ☐ Kidney Stones _____
- ☐ Rheumatoid Arthritis _____
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ HIV
- ☐ Alcoholism
- ☐ Scoliosis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Low Potassium
- ☐ Osteoporosis

Surgical History:

☐ No Previous Surgery

- ☐ Abdominal Surgery
- ☐ Angioplasty
- ☐ Back Surgery _____

If you have had back surgery, what part of your back?

- ☐ Lumbar (Lower Back)
- ☐ Thoracic (Middle Back)
- ☐ Unknown

If you have had back surgery, was this a Fusion Surgery?

☐ Yes ☐ No ☐ Unknown

- ☐ CABG
- ☐ Cardiac Pacemaker
- ☐ Gastric Bypass
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Mastectomy
- ☐ Neck Surgery
- ☐ Rotator Cuff Repair
- ☐ Thyroidectomy
- ☐ _____
- ☐ _____

List any prior diagnostic tests and treatments

Test/Treatment	Date(s)	Body Area Tested/Treated	Facility
CT Scan			
MRI			
EMG			
X-ray			
Physical Therapy			
Spinal Injection			
Chiropractic			
Massage			
Acupuncture			

Family Medical History (check family member if known)

☐ Alcoholism	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Alzheimer's disease	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Asthma	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Bleeding/Blood Disorder	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Cancer	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Cardiovascular Disease	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Colitis	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Congenital Heart Disease	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ COPD	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Coronary Artery Disease	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Depression	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Diabetes	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Elevated Lipids	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Genetic Disease	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ High Blood Pressure (Hypertension)	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Liver Disease	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Mental Illness	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Obesity	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Osteoporosis	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Parkinson's disease	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Kidney/Renal Disease	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Seizure Disorder	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Stroke	☐ Brother	☐ Father	☐ Mother	☐ Sister
☐ Thyroid Disorder	☐ Brother	☐ Father	☐ Mother	☐ Sister

Previous Spine Injury History:

Have you had a previous injury to your spine? ☐ Yes ☐ No If yes, what is the injury date

Is this injury from a Motor Vehicle Accident? ☐ Yes ☐ No If yes, what is the MVA date

Is this injury work related? ☐ Yes ☐ No If yes, what is the injury date _____

Were you referred to us by a provider?

If so, please list provider name and clinic:

Social History:

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children: ☐ Yes ☐ No Number of Sons _____ Number of Daughters _____

Hand Dominance: ☐ Right-Handed ☐ Left-Handed ☐ Ambidextrous

Occupation: _____

Employment Status: _____

Restrictions: _____

Have you ever used tobacco? ☐ No/Never ☐ Yes ☐ Former – Age when you quit _____

Type of tobacco used: _____

If cigarettes, how many packs per day? _____

Have you ever had a problem with drug dependency? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes – how much? _____ ☐ No