



Douglas E. Hemler, M.D. Board Certified PM&R, Pain Medicine, Electrodiagnostic Medicine

SPINE AND SPORT

Kyle C. Morgan, D.O. Board Eligible PM&R, Pain Medicine, Electrodiagnostic Medicine

Kirk Prochnio, P.A.-C.

PATIENT HEALTH HISTORY

NAME: Last First M Date of birth:

PHARMACY PREFERENCE (LOCATION): PHONE

WHO REFERRED YOU TO OUR CLINIC:

PURPOSE FOR VISIT: Please describe your pain?

Empty box for describing pain.

INJURY HISTORY

Table with injury history questions: Date of Injury, Date Pain Began, Was the onset of pain: Gradual/Sudden, Was the injury a result of any of the following? (Vehicle Accident, On the job Injury, Recreational Accident, Non work-related incident, No known cause, Other), Please briefly describe the accident/injury, If MVA, were you wearing your seatbelt?, Do you feel that this injury was your employers or another persons fault?

OTHER TREATING PROVIDERS

Table for listing other treating providers: Physician Name, Approximate Dates

CURRENT MEDICATIONS

Table for listing current medications: Medication Name, Dose, How Often Taken

Nonsurgical Orthopedics, Interventional Spine Procedures, Sports Medicine, Electrodiagnosis, Occupational Medicine, Pain Management, Rehabilitation

2801 Youngfield Street Suite 150

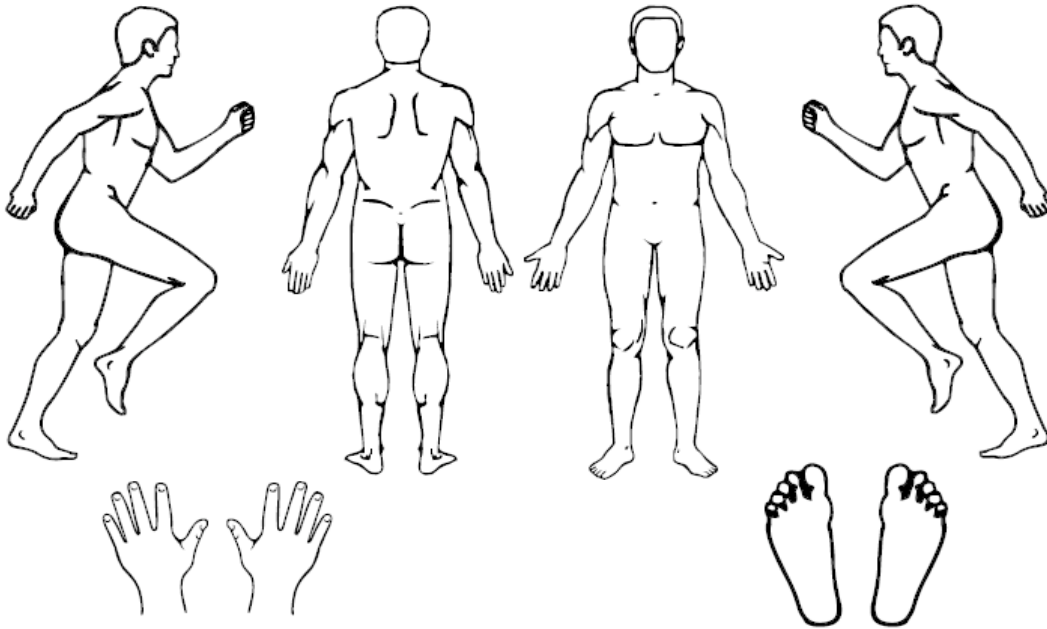
303-238-4277 Fax: 303-238-4977

ALLERGIES

<i>Medication Name</i>	<i>Type of Reaction</i>
Do you have environmental Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No Please list:
Do you have food Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No Please list:
Do you have a known allergy to Latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please place an "X" on the lines below indicating the level of your pain over the last two weeks:

- a.) What is your least pain? 0 -----5-----10(worst pain imaginable)
- B.) What is your worst pain? 0 -----5-----10(worst pain imaginable)
- a.) What is your pain today? 0 -----5-----10(worst pain imaginable)



Mark
worst
best times of day for your pain:

the
and

WORST	<input type="checkbox"/> Evening	BEST	<input type="checkbox"/> Evening
<input type="checkbox"/> First Awakening	<input type="checkbox"/> Nighttime	<input type="checkbox"/> First Awakening	<input type="checkbox"/> Nighttime
<input type="checkbox"/> Morning	<input type="checkbox"/> With Activity	<input type="checkbox"/> Morning	<input type="checkbox"/> With Activity
<input type="checkbox"/> Mid-day	<input type="checkbox"/> With Rest	<input type="checkbox"/> Mid-day	<input type="checkbox"/> With Rest

Please describe any problems with the following since the pain/injury:

Bowels:	Urination:	Sleep
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DIAGNOSTIC STUDIES

Please indicate if you have undergone any of the following studies and the results if you know them.

<i>Test</i>	<i>When</i>	<i>Where</i>	<i>Results</i>
<input type="checkbox"/> Plain X-Rays			
<input type="checkbox"/> CT Scan			
<input type="checkbox"/> Myelogram			
<input type="checkbox"/> MRI			
<input type="checkbox"/> Discography			
<input type="checkbox"/> Bone Scan			
<input type="checkbox"/> EMG			
<input type="checkbox"/> Other			

PAST MEDICAL HISTORY *Have you ever been DIAGNOSED with any of the following problems?*

	Yes	No	Year	Comment
Have you ever had similar or identical symptoms?	<input type="checkbox"/>	<input type="checkbox"/>		If yes, please explain:
CANCER (please list type):	<input type="checkbox"/>	<input type="checkbox"/>		
Cardiovascular Do you have a pacemaker High/Elevated Cholesterol High Blood Pressure Other Heart Problems	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Respiratory Asthma COPD Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Gastrointestinal Hepatitis Reflux Stomach ulcers	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Kidney Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>		
Mental and Emotional Depression (requiring treatment) Anxiety (requiring treatment)	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
Hematologic/Immunity Anemia HIV/AIDS Mononucleosis Bleeding after surgery Blood transfusion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Other Not Listed Above Problem:	<input type="checkbox"/>	<input type="checkbox"/>		

PAST HOSPITALIZATIONS AND SURGERIES

Have you ever been hospitalized for a medical problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list below:			
Year	Reason for Admission	Date	Physician

OTHER TREATMENTS

Please check list the other treatments you have had for this pain/injury.		
<input type="checkbox"/> Hot Packs <input type="checkbox"/> Ice <input type="checkbox"/> Ultrasound <input type="checkbox"/> Electrical Stimulation <input type="checkbox"/> Massage <input type="checkbox"/> TENS unit for home use <input type="checkbox"/> Traction <input type="checkbox"/> Back School	<input type="checkbox"/> Local (trigger point) injections <input type="checkbox"/> Epidural Injections <input type="checkbox"/> Facet block <input type="checkbox"/> Nerve Root Block <input type="checkbox"/> Acupuncture <input type="checkbox"/> Chiropractic Treatment <input type="checkbox"/> Osteopathic Manipulation <input type="checkbox"/> Body Mechanic Training	<input type="checkbox"/> Anti-inflammatory Medication <input type="checkbox"/> Narcotic Pain Medication <input type="checkbox"/> Muscle Relaxant Medications <input type="checkbox"/> Braces/supports <input type="checkbox"/> Aerobic Exercises <input type="checkbox"/> Home Exercise Program <input type="checkbox"/> Strengthening Exercises
Are you happy with the medical treatment you have received up to this point in time? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please explain:	

REVIEW OF SYSTEMS Do you CURRENTLY have any of the following problems?

	Yes	No	Comment
General Health Problems: Fever Chills Night Sweats Weight Loss/Gain > 10 lbs/1 month Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	What is your current Height: _____ Weight: _____
Head/Neck Problems: New Headache Vision/Eye problems Earache, loss of hearing Chronic sinus infections	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Cardiovascular Problems: Blacking out/Fainting Bluish discoloration of lips/fingernails Chest pain Irregular heartbeat/palpitations Swelling of ankles	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Respiratory Problems: Frequent non-productive cough Frequent productive cough Shortness of breath Short of breath climbing 1 flight of stairs Wheezing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Gastrointestinal Problems: Difficulty swallowing/food sticking in throat Abdominal pain Constipation Diarrhea Heartburn Nausea Vomiting Blood in stools Black, tar-like stools	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Neurologic Problems: Numbness Tingling Seizures Weakness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Urologic Problems: Blood in urine Difficulty starting urine stream Burning Leaking of urine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Mental and Emotional Problems: Depression (requiring treatment) Anxiety (requiring treatment)	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Endocrine Problems: Feel cold all the time Feel hot when others do not Increased appetite Diabetes Thyroid deficiency Thyroid excess	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Hematologic Problems: Swollen Lymph Nodes Bruising easily Bleeding into joints	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Skin Problems: Itching Rash	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	

LIFESTYLE AND ENVIRONMENTAL

Have you ever smoked? Do you smoke now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments (indicate amount per day):
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments (indicate amount per week):
Do you use any recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments (indicate frequency):

OCCUPATIONAL HISTORY

Where do you work?	How long have you worked there?	Job Title:
How Physically Demanding is your job?	<input type="checkbox"/> Very Heavy (frequently lifting > 100 pounds) <input type="checkbox"/> Heavy (frequently lifting > 60 pounds) <input type="checkbox"/> Moderate (frequently lifting > 30 pounds) <input type="checkbox"/> Light (frequently lifting < 30 pounds) <input type="checkbox"/> Sedentary (essentially no lifting)	
Please rate how emotionally stressful your job is: (0 = none, 10 = severe)	Comments:	
Are you currently working?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last day worked:
How satisfied are you with your job?	<input type="checkbox"/> Very satisfied <input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied <input type="checkbox"/> "It is the worst job I've ever had"
Work status today (please describe):		

FAMILY HISTORY *Please mark all that apply:*

					Maternal		Paternal	
	Mother	Father	Brother	Sister	Grandma	Grandpa	Grandma	Grandpa
Specific Anesthesia problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER (please list type) under check mark	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:								
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory:								
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic:								
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hematologic								
Bleeding/clotting problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature (Must be a parent or guardian for children 17 and under)

Date

For Office Use Only: