NEUROSCIENCE CENTER℠
Advanced Technology – Complete Care

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

PATIENT HISTORY FORM

NAME _____ DATE _____

DATE OF BIRTH _____ AGE _____

Name of the physician who referred you to see a neurosurgeon: _____

City and State of referring physician: _____

Is your referring physician a chiropractor? _____

Name of your family physician: _____

Do you see a Pain Management physician? Yes No WHO:_____

Have you previously been treated for this particular problem? Yes No

Did your physician send medical records? Yes No

HPI

Where is the pain located? _____

When did the problem start? _____

On a scale of 1 to 10, 10 being the worst, how severe is the pain? _____

Is there any particular time of day or activity when the pain is worse? _____

What have you found to help alleviate the pain? _____

Have you used or are using Anti-Inflammatory/Analgesic over-the-counter medications for pain? _____

If yes, provide the name, duration of use, did over-the-counter medications work?

_____

Have you received Physical Therapy? When? How long? _____

Have you had a DEXA scan? _____ If yes, when and where: _____

CHECK ALL THAT APPLY TO YOUR SYMPTOMS:

PAIN QUALITY:	INCREASE PAIN:	DECREASE PAIN:	ASSOCIATED SYMPTOMS:	
◊ sharp	◊ sitting	◊ sitting	◊weakness	◊ insomnia
◊ aching	◊ lying down	◊ lying down	◊ numbness	◊ pain wakes at night
◊ burning	◊ walking	◊ walking	◊ tingling	◊ sexual dysfunction
◊ shooting	◊ bending	◊ bending	◊ fever	◊ other _____
◊ constant	◊ weather	◊ weather	◊ weight loss	_____
◊ intermittent	◊ coughing/sneezing		◊ bowel/bladder problems	

PREVIOUS TREATMENTS FOR PAIN:

	TREATMENT	HELPFUL?	CURRENT/ONGOING	
TENS Unit?	◊ Y ◊ N	◊ Y ◊ N	◊ Y ◊ N	
Physical/Occupational Therapy?	◊ Y ◊ N	◊ Y ◊ N	◊ Y ◊ N	
Psychological Evaluation?	◊ Y ◊ N	◊ Y ◊ N	◊ Y ◊ N	WHO: _____
Chiropractic Treatment?	◊ Y ◊ N	◊ Y ◊ N	◊ Y ◊ N	WHO: _____
Nerve Blocks?	◊ Y ◊ N	◊ Y ◊ N	◊ Y ◊ N	WHO: _____
Surgeries?	◊ Y ◊ N	◊ Y ◊ N	Type _____	

Did this problem arise from an injury or accident? Yes No
If yes, please explain _____
Did this injury occur at work? Yes No
Have you had this problem before? Yes No
If so, when? _____
What type of work do you do? _____
Have you missed work due to the problem? _____
If so, when? _____
When was the last day you were able to work? _____
Have you had any test for this problem? Yes No

PERSONAL MEDICAL HISTORY: Have you ever been treated for or been told you have any of the following:

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Osteoporosis	☐	☐	Blood Clots	☐	☐
Angina	☐	☐	Asthma/COPD	☐	☐	Peripheral Vascular Disease	☐	☐
High Blood Pressure	☐	☐	Strokes/TIA	☐	☐	Depression	☐	☐
Heart Failure	☐	☐	Seizures	☐	☐	Anxiety	☐	☐
Heart Attack	☐	☐	Sleep apnea	☐	☐	Thyroid Disease	☐	☐
High Cholesterol	☐	☐	Seasonal allergies	☐	☐	Glaucoma	☐	☐
Coronary Artery Disease	☐	☐	Arthritis	☐	☐	Fibromyalgia	☐	☐
Pacemaker	☐	☐	Bleeding Disorder	☐	☐	Anemia	☐	☐
Migraines	☐	☐	Stomach Ulcer	☐	☐	Pancreatitis	☐	☐
Kidney Stones	☐	☐	Liver Disease	☐	☐	Diverticulosis	☐	☐
Kidney Disease	☐	☐	Collapsed Lung	☐	☐	Other: _____		
Cancer (Specify)	☐	☐	Reflux/GERD	☐	☐	_____		

Type: _____

PAST SURGICAL HISTORY

Please list all surgeries you have had and the date of surgery:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List all medications you are taking, including medicines not requiring a prescription (Over-The-Counter)

Medication	Dosage (mg)	No. of Tablets	Times Per Day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

NEUROSCIENCE CENTER℠
Advanced Technology – Complete Care

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

ALLERGIES

Medications you are allergic to: _____

Other allergies: _____

Latex allergies? Yes No

If you are taking any herbal medicines circle below or list: _____

Echinacea	Kava	Gingko Biloba
Ephedra	St. John's Wort	Vite
Garlic	Valerian	Valerian Root
Ginkgo	Ginseng	

FAMILY HISTORY

Is your father living? Yes No Age _____ Deceased at age _____

Is your mother living? Yes No Age _____ Deceased at age _____

Have any family members been diagnosed with the following:

	Father	Mother	Children	Brother/Sister	Grandparent
Diabetes					
Stroke					
Heart Trouble					
Cancer					
Epilepsy					
Seizures					
Asthma					
Thyroid Disease					
Migraines					
High Blood Pressure					

SOCIAL HISTORY

Marital Status: Single Married Widowed

Number of Children: _____ Do you live alone? Yes No

Do you smoke? Yes No If so, packs per day? _____ Number of years? _____
If you formerly smoked, how long has it been since you quit? _____
If you use tobacco of other forms, please list: _____

Do you drink? Yes No If so, how much? _____

If you smoke or drink, and find you need surgery, would you be willing to quit for one week prior to surgery and six weeks after surgery to decrease the chances of complications? Yes No

What is your occupation? _____ Hours a week at work? _____

Do you exercise routinely? Yes No If so, how often? _____
Are you participating in a weight program? _____

NEUROSCIENCE CENTER℠
Advanced Technology – Complete Care

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

REVIEW OF SYSTEMS- *Check ALL that apply*

Constitutional

[ ] Fatigue
[ ] Fever
[ ] Weakness
[ ] Weight Gain
[ ] Weight Loss

Musculoskeletal

[ ] Pain- Left, Right, or Bilateral
[ ] Spasm- Left, Right, or Bilateral
[ ] Weakness- Left, Right, or Bilateral

Vision

[ ] Blurry vision- Left, Right, or Bilateral
[ ] Other

Cardiology

[ ] Chest Pain
[ ] Palpitation

Tobacco Use:
Please select your current level of tobacco use.

[ ] Never smoked
[ ] Current, Everyday
[ ] Current, Some days
[ ] Former Smoker
[ ] Unknown

Worsening?:
Have any of your problems become worse?
YES NO
Explain:_____

_____

Any New Problems?:
YES NO
Explain:_____

Nose/Mouth/Throat

[ ] Hoarseness
[ ] Smell or Taste
[ ] Vertigo
[ ] Snoring
[ ] Other

Gastroenterology

[ ] Abdominal pain
[ ] Anorexia
[ ] Constipation
[ ] Diarrhea

Hematologic/Lymphatic

[ ] Anemia
[ ] Other

G.U.

[ ] Frequent urination
[ ] Urgent urination
[ ] Incontinence

Alcohol Use:

[ ] No
[ ] Yes, please specify amount

_____ drinks per month.

Hospitalization/Surgeries:
Have you been hospitalized or had surgery since your last visit?
Explain_____

_____

_____

_____

Neurology

[ ] Dizziness
[ ] Headaches
[ ] Memory
[ ] Numbness, Left or Right side
[ ] Sleep/Insomnia/Snoring
[ ] Tremor

Endocrine

[ ] Thyroid, High or Low
[ ] Diabetes

Pulmonary:
[ ] Persistent Cough
[ ] Wheezing

Psychology

[ ] Anxiety
[ ] Depression
[ ] Hallucinations

Skin

[ ] Breast lumps
[ ] Rash

Balance/Motor Skills:
In the past year, have you had any falls?

[ ] No
[ ] Yes, please specify number of falls

_____ falls in past year.

Primary Care Physician:

_____

NEUROSCIENCE CENTER℠
Advanced Technology – Complete Care

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

Please circle the appropriate test below and list the date and location.

Name of Test	Date	Location
MRI	_____	_____
CAT SCAN	_____	_____
ANGIOGRAM	_____	_____
SPINAL XRAYS	_____	_____
SKULL FILMS	_____	_____
EMG	_____	_____
NCV	_____	_____
TRIAL STIMULATOR	_____	_____
OTHERS	_____	_____

If surgery is required, would you be receptive to blood product? Yes No

Patient Signature _____ Date: _____

DO NOT WRITE BELOW THIS LINE

Vital signs: **B/P** _____ **Pulse** _____
Temp _____ **Weight** _____
BMI _____

ROS (Template) ☐

Neuro (Template) ☐

Exam (Template) ☐