PROVIDENCE
St. Mary
Neuroscience Institute

Name: ____ Today's Date: _____________________________________

Date of Birth: _____________________________________ Age: __________ Height: ________ Weight: _______

PCP: ____ Who Referred: ___________________________________

If not referred, how did you choose this office? ____

Why are you seeing the doctor today? ____

____

Please list major complaint(s) and describe their onset (i.e., lower back pain began in May 2012 after lifting):

____

____

____

Are you having any? ☐ Numbness Where? ________________________
☐ Weakness Where? ________________________
☐ Loss of bowl or bladder control

What makes your symptoms better (please circle all that apply): Nothing, rest, changing position, standing, sitting, walking, running, kneeling, bending, twisting.

What worsens your symptoms (please circle all that apply): Nothing, rest, changing position, standing, sitting, walking, running, kneeling, bending, twisting.

Is this visit related to an injury? ☐ Yes ☐ No On the job? ☐ Yes ☐ No

If so, date of injury: _________________________________ Date of last employment: ___________________________

Do you have any open worker's compensation claims of any kind? ☐ Yes ☐ No

Do you have a lawsuit pending? ☐ Yes ☐ No

Please circle the description which applies to your intensity of pain: Stable, unchanged, gradually worsening, rapidly worsening, gradually improving, rapidly improving, completely resolved.

How long has the problem been present? _____ Day(s), _____ Week(s), _____ Month(s), _____ Year(s)

What started the pain/problem? ____

Quality of the pain (mark up to four): ☐ Sharp ☐ Shooting ☐ Crushing ☐ Tight Band ☐ Numbing ☐ Pulsating ☐ Aching ☐ Tingling ☐ Dull ☐ Throbbing

How severe is the pain at the location described above? ☐ No Pain ☐ Mild ☐ Moderate ☐ Severe

Is the pain (check all that apply)? ☐ Rare ☐ Infrequent ☐ Occasional ☐ Intermittent ☐ Daily ☐ Continuous ☐ Weekly ☐ Monthly

What treatments have you tried for this problem?

□ Physical Therapy
□ TENS units
□ Narcotic Medications
□ Muscle Relaxers
□ Massage
□ Traction
□ Anti-inflammatories
□ Orthotics
□ Chiropractor
□ Surgery
□ Steroid injections
□ Braces
□ Other: ___________________________________

Previous physicians seen for this problem?

Physician	Specialty	City	Treatment

PAST MEDICAL HISTORY: Check all that apply □ None Apply

□ Abnormal heartbeat
□ Cirrhosis
□High blood pressure
Neuropathy: □ Hands □ Feet
□ ADHD
□ Depression
□High cholesterol
□ Poor circulation
□ Anemia
□ Down syndrome
□ HIV/AIDS
□ Seizure
□ Anxiety
□ Emphysema
□ Kidney failure
□ Spina bifida
□ Asthma
□ Gastric reflux
□ Kidney stones
□Stomach ulcers
□ Bleeding disorder
□ Gout
□Migraine
□ Stroke
□ Blood clots in leg
□ Heart attack
□ Multiple Sclerosis (MS)
□ Thyroid
□ Blood clots in lung
□ Heart failure
□ Neurofibromatosis
□ Tuberculosis
□ Cerebral palsy
□ Hepatitis B or C
□ Osteoporosis
□ Fibromyalgia
□ Osteoarthritis
□ Rheumatoid arthritis
□ Other Rheumatological Disease

Cancer: ____(type/treatment)

□ Diabetes: If yes, when was it diagnosed? ____
Currently controlled with: □ insulin □ oral medications □ diet

□ Other : ____

____

PAST SURGICAL HISTORY: ◻ No prior surgery

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia? ◻ Yes ◻ No
If yes, have you had any problems related to this? ◻ Yes ◻ No

Explain any problems with general anesthesia: ____

SOCIAL HISTORY: Work status
◻ Working ◻ Homemaker ◻ Unemployed ◻ Disabled ◻ On leave ◻ Retired ◻ Student

Occupation: ____

Education: ____

Marital status: ◻ Single ◻ Married ◻ Divorced ◻ Widowed

Children: ◻ No ◻ Yes, how many? ______________

Do you live alone? ◻ Yes ◻ No If no, who lives with you? ____

Are you currently smoking? ◻ Yes ◻ No If yes, how many pack/day? _____ And for how many years? _____

Have you previously quit smoking? If so, when did you quit? _____ How many years did you smoke? _____

How many packs a day did you previously smoke? _____ Other forms of tobacco used? ________________________

Alcohol use: ◻ Never ◻ Rare ◻ Social ◻ Frequently (more than twice a week)
◻ Alcoholic ◻ Recovering alcoholic

Illegal drug use: ◻ Never ◻ In the past ◻ Currently ◻ Types of drugs? ________________________________

Sexually active: ◻ Yes ◻ No

FAMILY HISTORY: Please fill in the illness information below with the options listed:

Alcoholism	Cancer	High blood pressure	Other Rheumatological Disease
Arthritis	Diabetes	Kidney problems	Seizure
Bleeding problems	Gout	Lung problems	Stroke
Blood clots	Heart problems	Mental Illness	

Other: ____

____

FAMILY MEMBER	ILLNESS	AGE	IF DECEASED, AGE AT DEATH AND CAUSE
Father			
Mother			
Brother(s)			
Sisters			
Children			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Paternal Uncle			
Paternal Aunt			
Maternal Uncle			
Maternal Aunt			

Family History Unknown ☐

Adopted ☐

REVIEW OF SYMPTOMS (past 72 hours):

COMPLETE THE NEXT TWO PAGES BY CIRCLING ISSUES THAT YOU HAVE HAD AND USE THE BLANKS TO FILL IN ADDITIONAL INFORMATION

EXAMPLE. Eye problems **Cataracts**

GENERAL

Fevers	______________	Anemia	______________
Night sweats	______________	Fatigue	______________
Weight change	Gained ______________	Lost ______________	

EYES

Eye problems	______________	Eye injury	______________
Impaired sight	______________	Double vision	______________
Eye glasses/contacts	______________	Transient blindness	______________

EARS/NOSE THROAT/MOUTH

Change sense taste/smell	______________	Voice change	______________
Hearing difficulty	______________	Difficulty swallowing	______________
Ringing in ears	______________	Snoring	______________
Drainage from ears	______________	Sleep apnea/CPAP	______________
Ear injury	______________	Sinus trouble	______________
Dizziness	______________	Dental work	______________

NEUROLOGICAL

Numbness/pain of arms	______________	Stroke	______________
Numbness/pain of legs	______________	Fainting spells	______________
Awake with numbness/pain	______________	Loss of consciousness	______________
Weakness	______________	Tremor/shaking	______________
Muscle aching	______________	Seizures	______________
Coordination difficulty	______________	Headaches	______________
Change in walk	______________	Migraine	______________
Head injury	______________	Memory loss	______________
Neck injury	______________	Speech difficulty	______________
Back injury	______________	Confusion	______________
Pain in neck	______________	Numbness of face	______________
Pain in back	______________		

PSYCHIATRIC

Depression	______________	Anxiety	______________
Difficulty sleeping	______________	Bipolar disorder	______________

HEART/CARDIOVASULAR

Heart attack	______________________	Chest pain	_______________________
Heart murmur	______________________	Swelling ankles	_______________________
Fluttering heart	______________________	Bloody coughing	_______________________
Shortness of breath	______________________	Asthma	_______________________
Cough	______________________	COPD/Emphysema	_______________________
Tuberculosis	______________________		

GASTROINTESTINAL

Bowel disease	______________________	Fecal/stool incontinence	_______________________
Nausea/vomiting	______________________	Liver/gallbladder disease	_______________________
Rectal bleeding/hemorrhoids	______________________	Abdominal pain	_______________________
Constipation	______________________		

REPRODUCTIVE/BLADDER/KIDNEY DISEASE

Frequent urination	______________________	Impotence	_______________________
Painful/difficult urination	______________________	Irregular period	_______________________
Urinary incontinence	______________________	Vaginal discharge	_______________________
Bladder problems	______________________		

ENDOCRINE

Diabetes	______________________	Osteoporosis/Osteopenia	_______________________
Thyroid disease	______________________	Drainage from breasts	_______________________

SKIN

Lump in breasts	______________________	Rash/Itch	______________________
Skin disease or skin changes	______________________		

HEMATOLOGIC/BLOOD DISORDERS

Enlarged lymph nodes	______________________	Cancer	______________________
Ease or unusual bleeding	______________________		

RHEUMATOLOGIC/JOINT

Joint pain/arthritis	______________________	Rheumatoid arthritis	______________________

Other Rheumatological Disease ____

Other Disease or Diagnosis ____

PAIN DIAGRAM

On the diagram below, please indicate where you are experiencing pain or other symptoms.

Use the following to describe your symptoms:

A = Ache

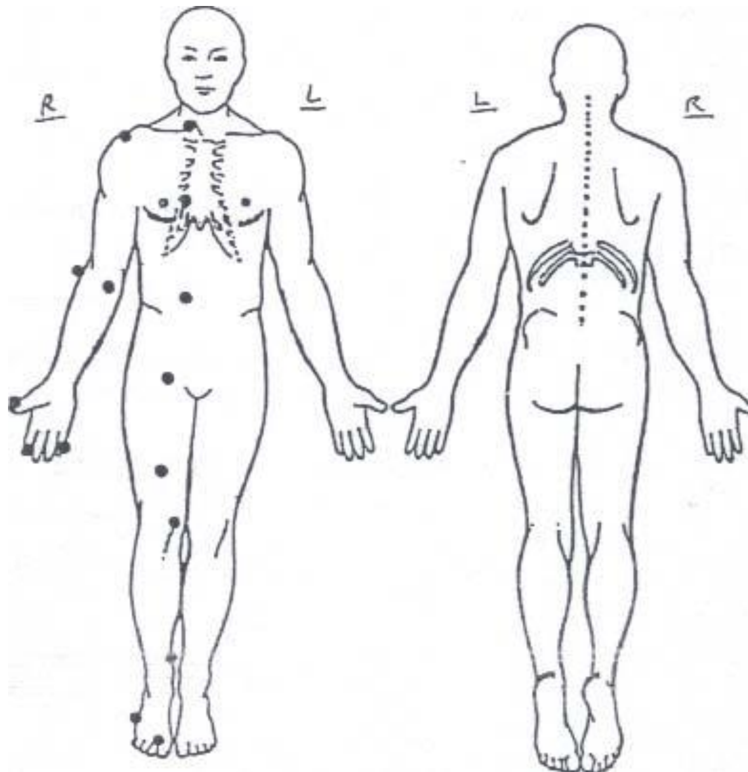
B = Burning

N = Numbness

P = Pins & Needles

S = Stabbing

O = Other



Please rate your usual level of pain on the following scale (circle one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Patient's signature: ______________________________ Provider signature: ______________________________

Date: ______________________________ Date: ______________________________