DuPage Medical Group
WE CARE FOR YOU

PATIENT INFORMATION

Date: ____________ Height: ____________ Weight: ____________ BMI: ____________

Allergies: ____

Last Name	First Name	Date of Birth	Current Age

Primary Care Physician	Referring Physician/Other Reference

REASONS FOR VISIT

☐ Work related ☐ Automobile accident ☐ Other injury

Primary reason for this visit and how long have you had this problem:

____

____

____

To what extent does the pain interfere with activities of daily living?

____

____

____

What do you expect from this visit?

____

____

____

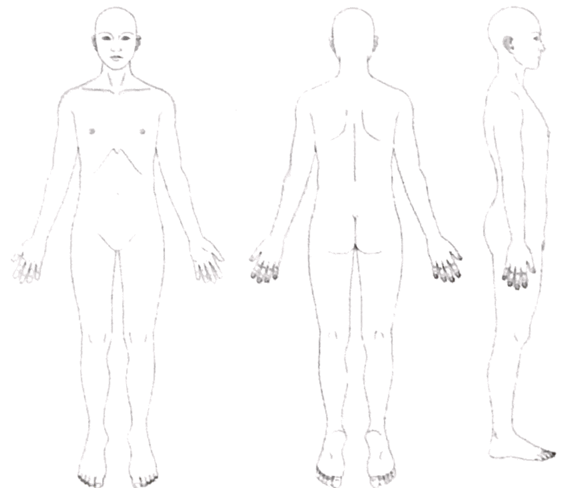
PAIN CHART

Mark the areas on your body where you feel the described sensations using the appropriate symbol from the list below.

PLEASE INCLUDE ALL AFFECTED AREAS

NUMBNESS ==== PINS & NEEDLES ooo

BURNING ACHING xxx STABBING ///



DX:

PLAN:

Patient Initials ____________ Date ____________

FUNCTIONAL HISTORY

Please indicate the activities that you require assistance performing:

☐ Driving ☐ Climbing stairs ☐ Household chores *(laundry, dishes, vacuuming, etc.)*
☐ Walking ☐ Using the washroom ☐ Outdoor yard work *(mowing lawns, raking gardening, etc.)*
☐ Hand writing ☐ Buttoning shirt ☐ Dropping objects
☐ Standing ☐ Bathing

Do you frequently drop things? ☐ Yes ☐ No

PREVIOUS TREATMENTS FOR THIS CONDITION

MEDICATIONS

Anti-inflammatories ______________________ ☐ Temporary relief ☐ Lasting relief ☐ No relief
Muscle relaxants ______________________ ☐ Temporary relief ☐ Lasting relief ☐ No relief
Pain medications ______________________ ☐ Temporary relief ☐ Lasting relief ☐ No relief
Other(s) ______________________ ☐ Temporary relief ☐ Lasting relief ☐ No relief

THERAPIES

Chiropractic Care ______________________ ☐ Temporary relief ☐ Lasting relief ☐ No relief
Physical therapy ______________________ ☐ Temporary relief ☐ Lasting relief ☐ No relief
Other(s) ______________________ ☐ Temporary relief ☐ Lasting relief ☐ No relief

INJECTIONS *(i.e. epidural steroid injections, nerve-root blocks)*

Date ________ Injection type ______________ ☐ Temporary relief ☐ Lasting relief ☐ No relief
Date ________ Injection type ______________ ☐ Temporary relief ☐ Lasting relief ☐ No relief

Previous treating doctors ______________________________________

Specialty(s) *(i.e. surgeon)* ______________________________________

Spine Surgery ______________________________________

____

______________ Patient Initials ______________ Date

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PATIENT INFORMATION

FAMILY HISTORY

What illnesses run in your family?

☐ Alcoholism ☐ Cancer ☐ High blood pressure ☐ Mental illness ☐ Spine disease

☐ Arthritis ☐ Diabetes ☐ Kidney disease ☐ Scoliosis

☐ Bleeding disorder ☐ Heart disease ☐ Other ______________________________

MEDICAL HISTORY

Please choose all current and past medical conditions:

☐ Abnormal heart rhythm
☐ Alcoholism
☐ Anorexia/bulimia
☐ Anxiety/depression
☐ Asthma
☐ Blood clot in leg/lung
☐ Cancer
Where ______________
☐ Dementia
☐ Diabetes
☐ Emphysema/COPD
☐ Fibromyalgia
☐ Heart attack
☐ Heart failure
☐ High blood pressure
☐ HIV
☐ Kidney failure
☐ Liver disease
☐ Multiple sclerosis
☐ No medical problem
☐ Osteoarthritis
☐ Osteoporosis
☐ Parkinson's disease
☐ Peripheral vascular disease
☐ Sleep apnea
☐ Stomach ulcers
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Use CPAP

SURGICAL HISTORY

Please choose all spinal surgeries you have had:

☐ Other Type of surgery ______________________________ Date(s) ____________

☐ Back Type of surgery ______________________________ Date(s) ____________

Type of surgery ______________________________ Date(s) ____________

SOCIAL HISTORY

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widow/Widower

Number of children ____________ ☐ At home ☐ Away Other dependents ____________

I live with my children or other relatives *(explain)* ______________________________ ☐ Yes ☐ No

DO YOU DRINK? ☐ Yes ☐ No

I drink ☐ Beer ☐ Wine ☐ "Hard" drinks

How many drinks do you have in a week? ____________ on average

DO YOU SMOKE? ☐ Yes ☐ No

I smoke ☐ Cigarettes ☐ Cigar/pipe ☐ Smokeless/leaf

Frequency ☐ Per day ____________ ☐ Years ____________

I quit ☐ When ____________

____________ Patient Initials ____________ Date

REVIEW OF SYSTEMS

Please check off any current or recent problems you have:

GENERAL
- ☐ Appetite change
- ☐ Difficulty sleeping
- ☐ Fevers or chills
- ☐ Marked fatigue
- ☐ Night sweats
- ☐ Unexplained weight loss

CARDIOVASCULAR
- ☐ Heart or chest pain
- ☐ Swollen ankles

MUSCULOSKELETAL
- ☐ Joint pain or swelling
- ☐ Muscle aches

DIGESTIVE
- ☐ Blood in stool
- ☐ Frequent constipation
- ☐ Frequent diarrhea
- ☐ Heartburn
- ☐ Nausea or vomiting
- ☐ Stomach pain
- ☐ Uncontrolled loss of stool

SKIN
- ☐ Easy bruising
- ☐ Rash

LUNG
- ☐ Shortness of breath

NEUROLOGICAL
- ☐ Blackouts/fainting
- ☐ Headaches/migraines
- ☐ Increased clumsiness
- ☐ Loss of balance
- ☐ Tremor

GENITOURINARY
- ☐ Burning on urination
- ☐ Difficulty starting urination
- ☐ Incontinence (stress)
- ☐ Unable to completely empty bladder

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ History of physical abuse
- ☐ History of sexual abuse
- ☐ Obsessive/compulsive disorder
- ☐ Other ______________________

____

WORK HISTORY

Employment Status

☐ Full time ☐ Part time ☐ Self-employed ☐ Disabled ☐ Retired ☐ Unemployed

Last day of employment: ______________________________

I work as a ______________________________

Describe job duties: ______________________________

☐ Yes	☐ No	Do you have any pending lawsuits?
☐ Yes	☐ No	Are you considering filing a lawsuit regarding this problem?
☐ Yes	☐ No	Do you have any workman's compensation claims pending?
☐ Yes	☐ No	Have you ever had any workman's compensation claims?
☐ Yes	☐ No	Do you expect to return to work in 6 months?

______________ Patient Initials ______________ Date