

MEDICAL HISTORY

1. What are your symptoms? _____

2. Where is your pain? Low back Upper Back Headaches
 Right leg Right arm Face
 Left leg Left arm
 Neck Other _____

3. How were you injured? NA Automobile accident Injured at work Other (*describe*) _____

4. How long have you had your pain? _____

5. How bad is your pain? 

6. What treatment have you had? None Medication Bed rest
 Physical therapy Chiropractic treatment Surgery
 Trigger point injection Epidural steroid injections

7. What medications have you tried? _____

8. Previous Neck/Back injury? Yes No

9. What makes your pain worse? Coughing Lifting Walking
 Standing Lying Down Other _____

10. What makes the pain better? _____

11. Have you experienced similar symptoms before? Yes No

12. Do you have any of the following? Clumsy hands Bladder problems Sexual dysfunction
 (*Check all that apply*) Unsteady walking Bowel problems Visual changes
 Electric Shocks in neck/back Weakness in arms or legs

13. Are you on disability? Yes No Since when? _____

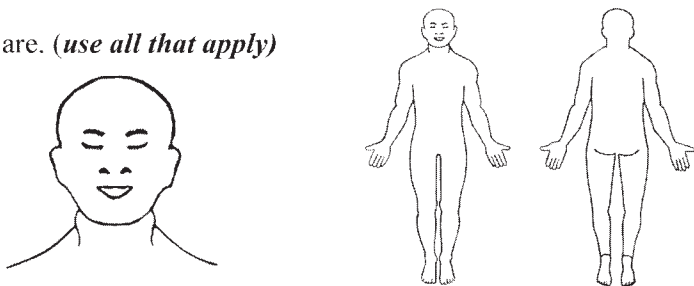
14. Have you missed work because of this problem? Yes No How much time? _____

15. Is there a lawsuit pending regarding the problem you are being evaluated for today? Yes No

Attorney _____

16. Mark the drawings below where your symptoms are. (*use all that apply*)

- Numbness +++
- Burning xxx
- Aching ==
- Stabbing ///
- Pins/Needles 000



Patient Name (please print): _____

Signature: _____ **Date:** _____

Are you **Right** handed or **Left** handed (check one)

Medical Problems/Illnesses *(please check all that apply)*

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> DVT (clots in legs) | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <i>(specify year)</i> _____ | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Stroke |
| <i>(please specify type)</i> _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> TIA ("mini stroke") |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyperthyroidism/
Hypothyroidism | <input type="checkbox"/> Tuberculosis/+ppd |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Panic attacks | | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Anxiety | | |
| <input type="checkbox"/> Other _____ | | |

Previous Surgeries *(please include operation and year)* Yes No

- Food Allergies** Yes No *(List all, and reactions you might have)* _____
- Dye Allergies** Yes No *(List all, and reactions you might have)* _____
- Latex Allergies** Yes No *(List all, and reactions you might have)* _____
- Drug Allergies** Yes No *(List all, and reactions you might have)* _____

Current Medications *(please include all herbal and vitamin supplements)* None

Family Medical Problems *(mother, father, siblings, children) (please check all that apply)*

- Bleeding disorders Diabetes High blood pressure: Heart disease Ulcers
- Stroke Cerebral Aneurysm Cancer *(type)* _____
- Other _____

Patient Name (please print): _____

Signature: _____ **Date:** _____

Social History Marital status: Single Married Widowed Divorced

Occupation: _____

Alcohol use: Yes No

Smoking Use: Never Quit Smoker Packs per day _____ Number of years _____

Review of Systems (please check all that apply)

Constitutional: Fever Chills Night sweats Weight loss Loss of energy **All negative**

Eyes: Blurred vision Double vision Loss of vision Eye pain **All negative**

Ears, Nose, Mouth, Throat: Ringing in ears Hearing loss **All negative**
 Hoarseness Facial pain Earache Dizziness

Cardiovascular: Chest pain Heart is racing Light-headedness **All negative**

Respiratory: Cough Wheezing Short of breath **All negative**

Gastrointestinal: Difficulty swallowing Nausea Vomiting Abdominal pain **All negative**
 Constipation Bowel incontinence

Genitourinary: Frequent urination Bladder incontinence **All negative**

Psychiatric: Sleep disturbances Anxiety Depression Panic attacks **All negative**

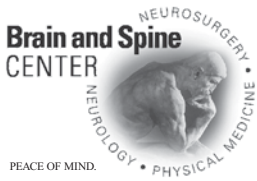
Hematologic/Lymphatic: Easy bruising Blood disorders Enlarged liver/spleen **All negative**

Skin: Rash Itching Pigmentation changes **All negative**

**If you are here for a work related injury
 please complete the back page**

Patient Name (please print): _____

Signature: _____ **Date:** _____



Workers' Compensation Intake Form

Date of injury: _____ Time of injury: _____ AM PM

Employer's Name: _____ Employer's Phone #: _____

Employer's Address: _____
(Complete address including City, State and Zip Code)

Address where ACCIDENT/INJURY occurred: _____
If other than employer's address

Explain in detail how the injury occurred: _____

Explain in detail the nature of your injury, including all parts of the body injured: _____

Have you received any medical care related to this injury before today's visit? YES NO
If yes, Where? _____ When? _____
With Whom? _____ Are you still under care? YES NO

Where you hospitalized for this injury? YES NO

Have you had any previous Workers' Compensation or Auto No-Fault injuries? YES NO
If yes, when and where were you treated for these injuries: _____

Are you disabled from performing your regular job duties? YES NO
Does any other Doctor have you off of work? YES NO If yes, who _____

Does your employer have light duties or other jobs you can perform? YES NO I'm unsure
Have you given your employer or supervisor notice of this injury? _____ Written Verbal

Have you completed a C-3 form and forwarded it to Workers' Compensation Board? YES NO
(Note: It is the patient's responsibility to file a C-3 form with the New York State Workers' Compensation Board.)

Do you have a Workers' Compensation Number? YES NO If yes, please list: _____

Insurance Carrier: _____ Claim#: _____

Address: _____

Phone#: _____ Adjuster: _____

My Worker's Compensation Case is Open Closed Controverted

Agreement and Acknowledgment

In the event I fail to prosecute the claim for workers' compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable worker's compensation case, I hereby agree to pay Brain and Spine Medical Services, PLLC, 400 International Drive, Williamsville, NY 14221, its usual and customary fees for services rendered.

Patient Name (please print): _____

Signature: _____ **Date:** _____