Please circle M.D. you are seeing today.

David A. Wong, M.D.

PATIENT NAME_____ **DOB**_____ **Age**_____
Soc Sec #_____ **Today's Date**_____
Referred By_____

PRESENT INJURY OR PROBLEM

What is the location of your spine pain? (Circle One)

Neck Mid Back Low Back

IF NECK PAIN

Most of my pain is in my neck _____
OR
Most of my pain is in my arm(s) _____
OR
I have equal amounts of pain in my neck and arm(s)
_____

I have also experienced
Hand numbness/tingling _____
Hand weakness _____
Hand clumsiness _____

IF LOW BACK PAIN

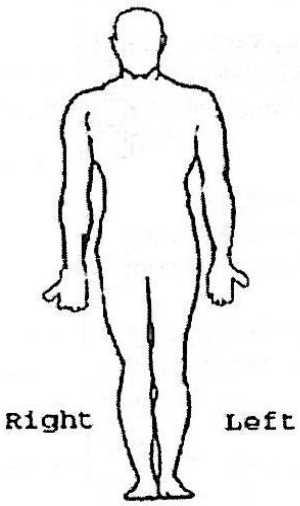
Most of my pain is in my back _____
OR
Most of my pain is in my leg(s) _____
OR
I have equal amounts of pain in my back and leg(s)
_____

I have also experienced
Leg/foot numbness/tingling _____
Leg/foot weakness _____
Leg/Foot clumsiness of gait _____

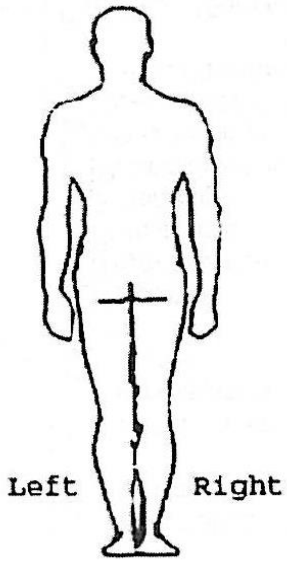
Would you be so kind as to draw your pain location (today) on the diagram below.

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Please include all affected areas.

PAIN/ACHE – XXXXX NUMBNESS - ====== PINS AND NEEDLES – 00000



FRONT



BACK

What activities increase your pain?

Standing _____

Sitting _____

Walking _____

Driving _____

Bending _____

Other- list:_____

_____

Do you have pain when trying to sleep?

Yes _____ No _____

Have you had any upset in bladder function?

Yes _____ No _____

Have you had any upset in bowel function?

Yes _____ No _____

Please proceed to next page.

PATIENT NAME

ONSET: **When did your symptoms first start?**_____**/**_____**/**_____
Was the onset Sudden **or** Gradual
Have you had problems like this before? No Yes If Yes, When _____**/**_____**/**_____
When did you first seek medical care for this problem? _____**/**_____**/**_____

What caused your symptoms? (Circle One) INJURY DON'T KNOW OTHER:_____

If an injury, was it (Circle One) Work Related Auto Accident Fall Lifting _____

PAIN**: How would you rate your pain – scale of 0-10 if *0 is no pain and 10 is intolerable*, as bad as it can be?**

On a bad day _____ **On a good day** _____ **Today** _____

ACTIVITY LEVEL: **How would you rate your activity level now? (Circle one)**
1. **I am able to do whatever activities I choose.**
2. **I have to be careful or cautious about what activities I do**
3. **I have several restrictions in my lifestyle at work or at home.**

Work Status (Circle One) OCCUPATION_____
1. **I am not employed. (Homemaker, student, retired, unemployed…)**
2. **I am working; this problem hasn't affected my work.**
3. **I am working less because of this problem – approximately** _____**% less.**
4. **I am working with some restrictions.**
5. **I have been off work since** _____**/**_____**/**_____
6. **I have been disabled since**_____**/**_____**/**_____
7. **How much work have you missed in the past year due to this problem?** _____**days**
8. **Is this a Worker's Compensation injury/problem? Yes / No**
9. **Is there an attorney involved with this injury/problem? Yes / No**

PREVIOUS TREATMENT FOR THIS INJURY/PROBLEM

X-rays/Tests for this problem:	**Date**	**Where were they done?**	**Did you bring the films or have them sent to us?**
Plain x-ray	_____/_____/_____		
MRI	_____/_____/_____		
CT Scan	_____/_____/_____		
Discogram	_____/_____/_____		
Other	_____/_____/_____		

Medications for this problem: (Pain pills, anti-inflammatories)

Medicine Type	**How Much**	**How Often**	**Results**

Injections for this problem: (nerve root injections, epidural steroid injections)

Injection Type	**Date**	**Results**

Surgeries for this problem or in this area: How many_____ **or None?**

Date	**Surgery Type**	**Surgeon**	**Kind of Doctor**
____/_____			
____/_____			

Other Treatments and date **Physical Therapy**_____**/Chiropractor**_____**/Brace**_____**/**

TENS unit_____**/Acupuncture**_____**/Exercises**_____**/Massage**_____**/**

Other_____

Please proceed to next page.

PATIENT NAME

Please Tell Us About YOUR Present Health Status

The following is a list of symptoms/illnesses. Indicate with a check whether you now have or have had in the past, any of these symptoms/illnesses. Please LEAVE BLANK **spots for any which** DO NOT **relate to you.**

Past	Present		Past	Present	
		CARDIOVASCULAR			NERVOUS SYSTEM
____	____	**High Blood Pressure**	____	____	**Epilepsy/Seizures**
____	____	**Chest Pain (Angina)**	____	____	**Dizzy/Fainting Spells**
____	____	**Heart Attack**	____	____	**Headaches**
____	____	**Heart Failure**	____	____	**Migraine Headaches**
____	____	**Heart Murmur**	____	____	**Neuropathy**
____	____	**Heart Valve Problems/Stents ___Y ___N**	____	____	**Loss of Balance**
____	____	**Stroke/TIA**	____	____	**Pain/tingling with neck motion**
____	____	**Blood Clots in legs/Blood Clots in the lungs**			
____	____	**Swelling in legs**			BLOOD DISORDERS
____	____	**Phlebitis**	____	____	**Anemia**
____	____	**Irregular heart beat/Arrhythmia**	____	____	**Sickle-cell anemia**
____	____	**Pacemaker**	____	____	**Hemophilia**
____	____	**High Cholesterol**			
		PULMONARY			
____	____	**Asthma**			JOINT DISEASE
____	____	**Chronic bronchitis**	____	____	**Previous sciatica/back problems**
____	____	**Emphysema**	____	____	**Arthritis**
____	____	**Tuberculosis**	____	____	**Degenerative Joint Disease**
____	____	**Pneumonia**	____	____	**Joint replacement**
____	____	**Chronic pulmonary Disease (COPD)**	____	____	**Gout**
____	____	**Shortness of breath**	____	____	**Fractures of bone(s)**
____	____	**Sleep Apnea/CPAP ___Y ___N**			
					URINARY SYSTEM
		GASTROINTESTINAL SYSTEM	____	____	**Bladder/kidney infections**
____	____	**Ulcers/GI bleeding**	____	____	**Kidney stones**
____	____	**Stomach irritation/heartburn**	____	____	**Loss of control of urine**
____	____	**Hiatal hernia**	____	____	**Enlarged prostate/urine flow problems**
____	____	**Gallbladder problems**			
____	____	**Liver disease/hepatitis**			INFECTIOUS DISEASE
____	____	**Black tarry stools/rectal bleeding**	____	____	**Hepatitis**
___	____	**Diverticulosis**	____	____	**AIDS or positive HIV**
____	____	**Hernia**	____	____	**Sexually transmitted disease**
			____	____	**Polio**
		ENDOCRINE SYSTEM	____	____	**Herpes**
____	____	**Diabetes**	____	____	**Rheumatic fever**
____	____	**Thyroid disease**	____	____	**Scarlet fever**
____	____	**Addison's/Cushing's disease**	____	____	**Malaria**
					CANCER
		SKIN/MISC	____	____	**Head/Neck/Thyroid**
____	____	**Eczema**	____	____	**Blood/bone**
____	____	**Psoriasis**	____	____	**Breast/Lung**
____	____	**Lupus**	____	____	**Skin**
____	____	**Fibromyalgia**	____	____	**Bowel/Kidney**
____	____	**Bruise easily**	____	____	**Prostate**
			____	____	**Other**
		OB GYN			
____	____	**Fibroids**			PSYCHOLOGICAL DISORDERS
____	____	**Endometriosis**	____	____	**Depression**
____	____	**Tubes Tied**	____	____	**Nervous Disorder**
____	____	**Ovarian Cysts**	____	____	**Addictive Disorder (Drugs/Alcohol)**
____	____	**Post Menopause**	____	____	**Eating Disorder**

ALLERGIES (list below)

Food: _____

Medicine: _____

_____

Other Health Problems (list below)

not listed: _____

_____

_____

Do you feel chronically fatigued? _____ Yes _____ No

Please proceed to next page.

PATIENT NAME

Age_____ Height_____ Weight_____ Are you ____left hand/____right handed?
Have you experienced unexplained weight loss in the past year? ____ Yes ____ No How much?_____
Have you experienced any unexplained weight gain in the past year? _____Yes _____ No How much?_____

Do you use tobacco? ____ Yes ____ No; If yes, how much?_____
____ Quit How long ago?_____
Do you drink alcohol? ____ Yes ____ No If yes, how much?_____
____ Quit How long ago?_____
Recreational drug use? ____ Yes ____ No If yes, how much?_____
____ Quit How long ago?_____

Please list all surgeries and hospitalizations you have had and the year they took place.

Have you ever had a blood transfusion? _____Yes _____No When_____
Have you had any *anesthetic* problems such as _____Difficulty inserting breathing tube,
_____High fever during or after anesthesia
_____Significant nausea or vomiting after surgery
_____Other (list)

Please list all current medications, strength, and how often you take them. List even those medications that do not need a prescription.

For your SPINE problem **For OTHER health problems.**

List any herbal medications you have used.

FAMILY HISTORY

Please circle any health problems diagnosed in your immediate family and note who:

Condition	Who	Condition	Who	Condition	Who
Arthritis/Rheumatism	_____	Liver problems	_____	Hypertension	_____
Sciatic/back problems	_____	Cancer	_____	Heart Attack	_____
Breathing problems	_____	Diabetes	_____	Angina	_____
Bleeding problems	_____	Kidney Disease	_____	Other	_____

Is there anything else you feel the doctor should know about your lifestyle or medical history?

Sorry the form took so long to fill out but it really helps us.
Thank you **for helping us to help you. David A Wong, M.D.**