



**Past Medical/Surgical History:** if YES please explain on the spaces provided

	<b>Past</b>	<b>Current</b>		<b>Past</b>	<b>Current</b>		
headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	GERD/ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	fracture	<input type="checkbox"/>	<input type="checkbox"/>	_____
lung disease/asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	_____
blood clots	<input type="checkbox"/>	<input type="checkbox"/>	_____	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	pinched nerve	<input type="checkbox"/>	<input type="checkbox"/>	_____
heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	psychiatric treatments	<input type="checkbox"/>	<input type="checkbox"/>	_____
gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (please explain)	_____						
Surgeries (please include dates)	_____						

**Family History:** (please list all known medical conditions present/past in parents, siblings, grandparents)

**Social History:**

Marital Status: single married separated divorced widowed other \_\_\_\_\_

Occupation: \_\_\_\_\_ full-time part-time retired disabled not working

Education: highest grade completed \_\_\_\_\_ Hobbies: \_\_\_\_\_

Smoking: yes no if yes: how many packs per day? \_\_\_\_\_ how long? \_\_\_\_\_

Alcohol: yes no if yes: how many drinks per day? \_\_\_\_\_ how long? \_\_\_\_\_ socially/occasionally

Street Drugs (illegal or abused prescription): yes no if yes, explain \_\_\_\_\_

Have you ever had an alcohol or drug abuse problem in the past? yes no if yes, explain \_\_\_\_\_

**Radiological Tests:** Please include all tests applicable to current pain problem performed in the last 5 years

X-Ray \_\_\_\_\_

CT scan \_\_\_\_\_

MRI \_\_\_\_\_

Myleogram \_\_\_\_\_

Other \_\_\_\_\_

**Treatment Goals:**  Be more active and functional  Improve relations with family

Return to work  Other \_\_\_\_\_

**I certify that I have truthfully answered all questions to the best of my ability, without knowingly withholding any information concerning problems either past or present.**

Patient signature \_\_\_\_\_ Date \_\_\_\_\_