North Pinellas Spine & Joint

Dr. Joshua Bly

## GENERAL INFORMATION

Patient Name: _____ Date: _____

Primary Care Physician's Name: _____

Sex: ❑ Male ❑ Female Date of Birth: _____ S/S #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Patient Employer: _____ Patient Occupation: _____

Insured's Name: _____ Relation to Patient: _____

Insured's Employer: _____ Insured's S/S #: _____

Insured's Date of Birth: _____ Referred for Treatment by: _____

Health Insurance Plan: _____ Group #: _____ Member #: _____

## PAST OR PRESENT SYMPTOMS, CONDITIONS OR HABITS

**Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.**

| Symptom | Past | Present | Symptom | Past | Present |
|---|---|---|---|---|---|
| Neck Pain | ❑ | ❑ | High Blood Pressure | ❑ | ❑ |
| Shoulder Pain | ❑ | ❑ | Heart Condition | ❑ | ❑ |
| Arm/Elbow Pain | ❑ | ❑ | Respiratory Condition | ❑ | ❑ |
| Hand Pain | ❑ | ❑ | Digestive Problems | ❑ | ❑ |
| Upper Back Pain | ❑ | ❑ | Kidney/Bladder Problems | ❑ | ❑ |
| Lower Back Pain | ❑ | ❑ | Menstrual Problems | ❑ | ❑ |
| Pain in Upper Leg or Hip | ❑ | ❑ | Breast Soreness/Lump | ❑ | ❑ |
| Pain in Lower Leg or Knee | ❑ | ❑ | Sinus Conditions | ❑ | ❑ |
| Pain in Ankle or Foot | ❑ | ❑ | Allergies/Asthma | ❑ | ❑ |
| Numbness/Tingling in Arms or Legs | ❑ | ❑ | Cancer | ❑ | ❑ |
| Jaw Pain | ❑ | ❑ | Stroke | ❑ | ❑ |
| Swelling/Stiffness of Joints | ❑ | ❑ | Excessive Weight Loss/Gain | ❑ | ❑ |
| Headaches | ❑ | ❑ | Skin Condition | ❑ | ❑ |
| Dizziness | ❑ | ❑ | Arthritis | ❑ | ❑ |
| Fainting Spells | ❑ | ❑ | Diabetes | ❑ | ❑ |
| Convulsions | ❑ | ❑ | Prostate Condition | ❑ | ❑ |
| General Prolonged Fatigue | ❑ | ❑ | Constipation/Diarrhea | ❑ | ❑ |
| Condition of Uterus/Ovaries | ❑ | ❑ | Pregnancy | ❑ | ❑ |

**Tobacco Use:**
❑ Past ❑ Present
❑ Occasional ❑ Moderate ❑ Heavy

**Alcohol Use:**
❑ Past ❑ Present
❑ Occasional ❑ Moderate ❑ Heavy

**Please list any medications or nutritional supplements you take:**

_____
_____
_____
_____
_____
_____
_____
_____

## INJURIES, ACCIDENTS AND SURGERIES

**Please list the description and date of any injuries, accidents or surgeries you have had.**

Broken Bones _____

Falls _____

Surgeries _____

Automobile Accidents _____

Work Injuries _____

Other _____

## COMPLAINT HISTORY



1. Describe your chief complaint: _____

   How long have you had this condition?: _____ Date of onset: _____

2. How would you describe the pain?:

   ❑ Sharp ❑ Soreness ❑ Throbbing ❑ Shooting
   ❑ Spasm ❑ Burning ❑ Ache ❑ Weakness ❑ Numbness

3. How would you rate the intensity of your pain? (Circle the appropriate number)

   0 1 2 3 4 5 6 7 8 9 10
   (No Pain) (Moderate Pain) (Terrible/Unbearable Pain)

4. How often is the pain present?

   ❑ Constant (81-100%) ❑ Frequent (51-80%) ❑ Occasional (26-50%) ❑ Intermittent (25% or Less)

5. Since your problem began is the pain:

   ❑ Getting Worse ❑ Getting Better ❑ Staying the same

6. How did your problem begin?

   ❑ Auto Accident ❑ Work Related Accident ❑ Other Type of Accident ❑ Gradual ❑ Sudden ❑ No Specific Reason

   Explain: _____

7. What makes your problem better?

   ❑ Nothing ❑ Walking ❑ Standing ❑ Sitting ❑ Moving Around/Exercise ❑ Lying Around ❑ Inactivity

8. What makes your problem worse?

   ❑ Nothing ❑ Walking ❑ Standing ❑ Sitting ❑ Moving Around/Exercise ❑ Lying Around ❑ Inactivity

9. Are you currently taking any medications? ❑ Yes ❑ No

   If yes, please describe: _____

10. Were you previously treated for an earlier occurrence of the same condition? ❑ Yes ❑ No

    If yes, by whom? ❑ MD/DO ❑ Chiropractor ❑ Physical Therapist ❑ Other

    What were the approximate dates, type of treatment and the results? _____

11. What is your physical activity at work?

    ❑ Mostly Sitting ❑ Light Manual Labor ❑ Moderate Manual Labor ❑ Heavy Manual Labor

12. Do you exercise?

    ❑ No Regular Exercise ❑ 1-2 times a Week ❑ 3-4 Times a Week ❑ 5-7 times a Week ❑ Sports
    ❑ Cardiovascular ❑ Stretching ❑ Weight Machine ❑ Free Weights Type _____

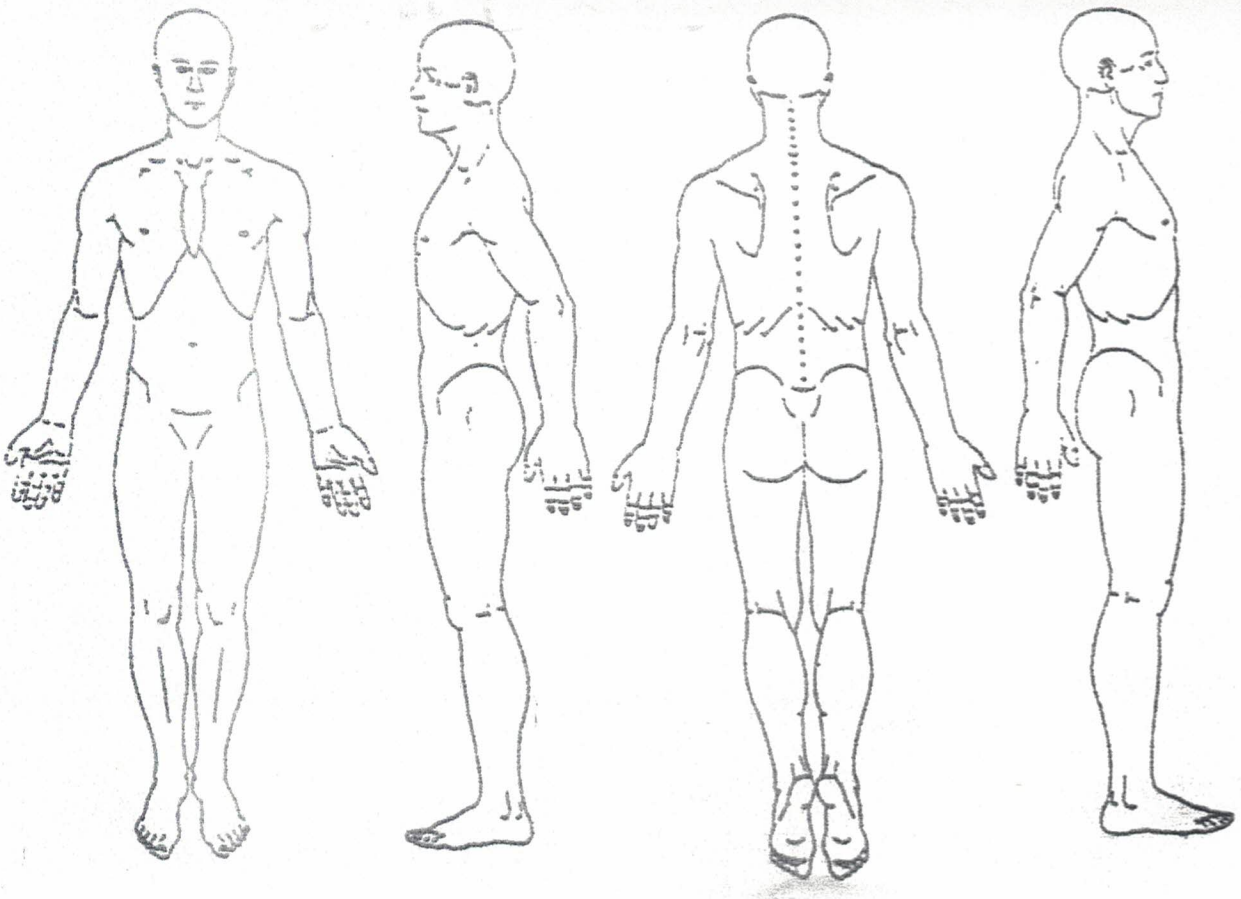
13. What is your present general stress level?

    ❑ No Stress ❑ Minimal Stress ❑ Moderate Stress ❑ Greatly Stressed

14. Is your problem affecting your ability to work or do other routine daily activities?

    ❑ No Effect ❑ Cannot Work ❑ Totally Disables
    ❑ Have some limited physical restrictions, but can function
    ❑ Cannot function without assistance ❑ Need some assistance with daily activities

PROVIDER INITIALS



## TYPE OF PAIN YOU ARE CURRENTLY EXPERIENCING...

Place appropriate symbol or letter on the diagram.

Ache = AAAAA  Numbness = NNNNN  Pins and Needles = OOOOO

Burning = XXXXX  Stabbing = /////

Please place a mark on the line that corresponds to your **current** pain level.

NO PAIN  WORSE PAIN POSSIBLE

Patient Name_____Date_____

**Doctors Notes**

_____

_____

_____

_____