MEDICAL HISTORY

1. What are your symptoms? _____

_____

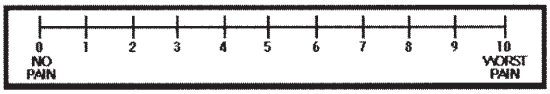
2. Where is your pain?
❒ Low back ❒ Upper Back ❒ Headaches
❒ Right leg ❒ Right arm ❒ Face
❒ Left leg ❒ Left arm
❒ Neck ❒ Other _____

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? ***(Check all that apply)***
❒ Clumsy hands ❒ Bladder problems ❒ Sexual dysfunction
❒ 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? _____

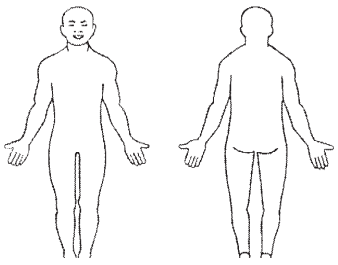
14. Have you missed work because of this problem? ❒ Yes ❒ No How much time? _____

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:** _____

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Brain and Spine Medical Services, PLLC

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

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

☐ Anemia
☐ Bleeding disorders
☐ Hemophilia
☐ Arthritis
☐ Asthma
☐ COPD/Emphysema
☐ Cancer
(please specify type)
_____
☐ Diabetes
☐ Depression
☐ Panic attacks
☐ Anxiety

☐ DVT (clots in legs)
☐ Hepatitis
☐ Heart Attack
*(specify year)*_____
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Head Trauma
☐ High Blood Pressure
☐ Hyperthyroidism/
Hypothyroidism
☐ High Cholesterol

☐ Kidney Stones
☐ Lung disease
☐ Migraines
☐ Pneumonia

☐ Rheumatic Fever
☐ Seizures
☐ Stroke
☐ TIA ("mini stroke")
☐ Tuberculosis/+ppd
☐ Ulcers
☐ Urinary tract infections

☐ 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:**_____

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Brain and Spine Medical Services, PLLC

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 or
A No-Fault injury, please complete the back page.

Patient Name (please print): _____

Signature: _____ **Date:** _____

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_____ No Fault Injury OR _____Workers' Compensation Injury

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:**_____