



1301 Route 72 West, Suite 240 Manahawkin, NJ 08050 P: (732) 359-5444 / F: (732)276-9645

Initial Visit Location: Manahawkin **Date:** _____

Last Name: _____ First Name: _____

D.O.B: _____ Age: _____ Height: _____ Weight: _____ R. Handed L. Handed

Pain Background

Is this related to an open Workman’s Comp or Motor Vehicle Accident? Yes No

When did your pain begin? (What year?) _____ Pain Location: (Low back?) _____

What treatments have you tried?

- Acupuncture Physical Therapy TENS Unit Epidural Injection Narcotic Pain meds
- Chiropractor Surgery Aquatherapy Nerve Block Trigger Point Injections
- Pain Management NSAIDs Muscle relaxers Spinal Cord Stim Neurontin/Lyrica

If other, Please List: _____

Have you had any imaging/radiology?

X-ray MRI CT Scan EMG If yes, where were they done? _____

Please check the ones that apply to your pain:

- Sharp Stabbing Throbbing Aching Burning Tingling Shooting Dull

Please rate your pain (please circle): 1 – 3 4 – 6 7 – 10

Mild Moderate Severe

What makes the pain better?

- Heat Resting Exercise Lying down Physical Therapy Exercise Injections
- Ice Massage Sitting TENS Unit Sleeping Pain Medications muscle relaxers
- NSAIDs Neurontin/Lyrica List: _____

What makes the pain worse?

- Walking Bending Lifting Stooping Reaching Lying down Sitting
- Weather Standing Exercise Twisting List: _____

Name: _____ D.O.B. _____ Date: _____

Medical History:



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Epilepsy/Seizure Stroke Brain tumor Headaches Meniere's Disease Vertigo MS Glaucoma
Cataracts Hard of hearing Heart Attack High blood pressure High cholesterol Diabetes are you on
insulin yes no Blood clots Bleeding disorders Pacemaker Defibrillator Cardiac stent Mitral
Valve Prolapse Irregular Heart Rhythm A-Fib COPD/Emphysema Asthma Bronchitis Pulmonary
Embolism Sarcoidosis Tuberculosis Heartburn Stomach Ulcer Gallbladder stones
Diverticulitis/losis Colitis Irritable Bowel Crohn's disease Celiac disease Hepatitis Liver disease
Cirrhosis Fatty Liver Kidney disease Kidney stones or stents Fibromyalgia Eczema Psoriasis
Cellulitis Rheumatoid Arthritis Lyme disease HIV/AIDS Lupus Epstein Barr Cancer_____

Others:_____

Family History:

Surgical History:

Social History:

Do you use tobacco products: Yes No Do you have trouble sleeping? Yes No
If yes, how much: _____

Do you drink alcohol? Yes No Do you suffer with anxiety? Yes No

Do you use recreational Drugs? Yes No Do you suffer with depression? Yes No

Have you ever been treated for substance Abuse? Yes No

Are you pregnant or breast feeding? Yes No

Allergies? Drug or Seasonal Allergies?

If yes, what are they?_____

Medication List:

Pharmacy Information:



1301 Route 72 West, Suite 240 Manahawkin, NJ 08050 P: (732) 359-5444 / F: (732)276-9645

Name: _____ Town/Address: _____

Phone Number: _____

Primary Care Physician/Referring Physician:

Primary Care Physician: _____ Phone Number: _____

Address: _____

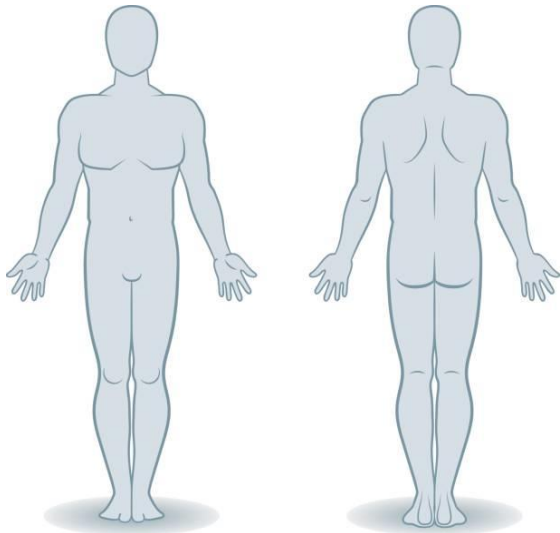
Referring Physician: _____ Phone Number: _____

Address: _____

By signing below, I certify that this information is accurate and current.

Patient Signature: _____ Date: _____

Parent or Guardians Signature: _____ Date: _____



*****Mark your pain locations.