4 E. Jimmie Leeds Rd., Suite #3, Galloway, NJ 08205 P: (732) 359-5444 / F: (732)276-9645

Initial Visit Location: ☐ Galloway ***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 **Mild** 4 – 6 **Moderate** 7 – 10 **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:_____

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Medical History:

☐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

If yes, how much: _____

Do you have trouble sleeping? ☐Yes ☐No

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:

_____

_____

_____

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Pharmacy Information:

Name:_____ Town/Address:_____

Phone Number:_____

Primary Care Physician/Referring Physician:

Primary Care Physician:_____ Phone Number:_____

Address:_____

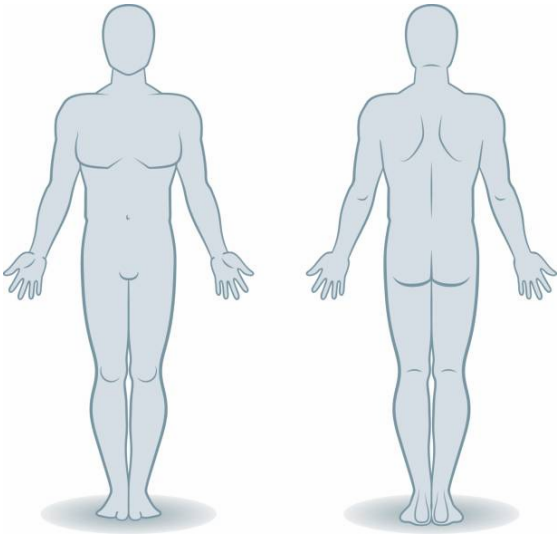
Referring Physician:_____ Phone Number:_____

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.