iROM

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INTAKE HISTORY

Name _____ Date _____/_____/_____

Address _____ City _____St_____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Referred by _____

Age _____ Sex _____ Weight _____ Height _____ Date of Birth _____/_____/_____

Primary Care Physician _____Office #_____

Health Insurance Carrier _____ ☐ No Health Insurance

HISTORY OF PRESENT ILLNESS

If you have more than one body area you want evaluated, please number the areas in order of severity and indicate Left or Right

	Neck pain		Arm pain from neck		Mid back pain		Low back pain		Leg pain from back
	Shoulder		Elbow		Wrist/forearm		Hand		Knee
	Ankle		Foot		Headaches		Fibromyalgia		Hips

Please list other _____

Do you participate with any form of state funded Medicaid Health Insurance program? ☐ Yes ☐ No

INJURY: Are you claiming a work related or motor vehicle related injury at this time?: ☐ Yes ☐ No
If yes, what type of injury are you claiming: ☐ Motor Vehicle ☐ Work Related Injury ☐ Other Injury such as slip and fall
Date of Injury: _____

DISABILITY:
Are you currently on Social Security Disability? ☐ Yes ☐ No
Are you receiving any other disability benefits? ☐ Yes ☐ No
Are you planning on asking Dr. Brown for assistance in receiving disability benefits? ☐ Yes ☐ No

Please provide a **BRIEF** chronological history of each problem checked above.
Describe how the problem started, consultations and treatments you have received & anything else you think we need to know.

PROBLEM #1:

Location of pain: _____

My pain remains: ☐ Localized ☐ Radiates Radiates into my _____

Onset of pain: ☐ Gradual ☐ Sudden

First onset of pain was: _____ months ago _____ years ago

Pain is made worse by: ☐ Sitting ☐ Standing ☐ Bending/Stooping ☐ Laying down ☐ Bending backward ☐ Exercise ☐ Other _____

Conditions is: ☐ Getting worse ☐ Getting better ☐ Remains the same

Pain is relieved by: ☐ Sitting ☐ Rest ☐ Meds ☐ Heat ☐ Ice ☐ Walking ☐ Exercise ☐ Therapy ☐ Chiropractic ☐ Other_____

Pain affects my work? ☐ Yes ☐ No ☐ Sometimes

Pain affects my relationships? ☐ Yes ☐ No ☐ Sometimes

Because of my pain I am unable to do things I like such as: _____

_____

Anything else the doctor needs to know about pain in this area: _____

_____

LEVEL OF PAIN IN PROBLEM AREA #1

On a scale of 1-10; 0 suggests no pain and 10 suggests the worst pain possible, please describe the following:

Pain at its least?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1

Pain at its worst?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1

Pain right now?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1

How much does your pain interfere with sleep?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1

PROBLEM #2:

Location of pain: _____

My pain remains: ☐ Localized ☐ Radiates Radiates into my _____

Onset of pain: ☐ Gradual ☐ Sudden

First onset of pain was: _____ months ago _____ years ago

Pain is made worse by: ☐ Sitting ☐ Standing ☐ Bending/Stooping ☐ Laying down ☐ Bending backward

☐ Exercise ☐ Other _____

Conditions is: ☐ Getting worse ☐ Getting better ☐ Remains the same

Pain is relieved by: ☐ Sitting ☐ Rest ☐ Meds ☐ Heat

☐ Ice ☐ Walking ☐ Exercise ☐ Therapy ☐ Chiropractic

☐ Other_____

Pain affects my work? ☐ Yes ☐ No ☐ Sometimes

Pain affects my relationships? ☐ Yes ☐ No ☐ Sometimes

Because of my pain I am unable to do things I like such as: _____

_____

Anything else the doctor needs to know about pain in this area: _____

_____

LEVEL OF PAIN IN PROBLEM AREA #2

On a scale of 1-10; 0 suggests no pain and 10 suggests the worst pain possible, please describe the following:

Pain at its least?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1

Pain at its worst?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1

Pain right now?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1

How much does your pain interfere with sleep?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1

PROBLEM #3:

Location of pain: _____

My pain remains: ☐ Localized ☐ Radiates Radiates into my _____

Onset of pain: ☐ Gradual ☐ Sudden

First onset of pain was: _____ months ago _____ years ago

Pain is made worse by: ☐ Sitting ☐ Standing ☐ Bending/Stooping ☐ Laying down ☐ Bending backward

☐ Exercise ☐ Other _____

Conditions is: ☐ Getting worse ☐ Getting better ☐ Remains the same

Pain is relieved by: ☐ Sitting ☐ Rest ☐ Meds ☐ Heat

☐ Ice ☐ Walking ☐ Exercise ☐ Therapy ☐ Chiropractic

☐ Other_____

Pain affects my work? ☐ Yes ☐ No ☐ Sometimes

Pain affects my relationships? ☐ Yes ☐ No ☐ Sometimes

Because of my pain I am unable to do things I like such as: _____

_____

Anything else the doctor needs to know about pain in this area: _____

_____

LEVEL OF PAIN IN PROBLEM AREA #3

On a scale of 1-10; 0 suggests no pain and 10 suggests the worst pain possible, please describe the following:

Pain at its least?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1

Pain at its worst?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1

Pain right now?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1

How much does your pain interfere with sleep?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1

Other pain or orthopedic problems (List body region effected):

- _____ - _____
- _____ - _____
- _____ - _____

Please check all that describe your pain:

☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Sharp ☐ Tingling ☐ Cramping ☐ Burning ☐ Aching ☐ Numbness

☐ Heavy ☐ Tender ☐ Splitting ☐ Tiring ☐ Exhausting ☐ Sickening ☐ Fearful ☐ Punishing ☐ Cruel

What treatments have you tried?

☐ Medications ☐ Exercise ☐ Massage ☐ Chiropractic ☐ Acupuncture ☐ Brace ☐ Physical Therapy

☐ Hot Packs ☐ Ice Packs ☐ Nerve Block ☐ Injections ☐ Biofeedback ☐ TENS Unit ☐ Traction

☐ Psychologist ☐ Surgery

Were any of these treatments helpful? ☐ Yes ☐ No Which were helpful? _____

Sleep:

Do you have interference with your sleep? ☐ Yes ☐ No ☐ Sometimes

On the average how long does it take you to fall asleep? _____

I sleep _____ hours per night. If you wake, how long does it take to fall back asleep? _____

Reason for sleeping difficulties?_____

Do you snore? ☐ Yes ☐ No

Do you wake gasping for air? ☐ Yes ☐ No

Do you have sleep apnea? ☐ Yes ☐ No

Do you use a BIPAP? ☐ Yes ☐ No

Previous medications utilized?

NSAIDS ☐ Asprin ☐ Ibuprofin ☐ Advil ☐ Motrin ☐ Naprosyn ☐ Other_____

Relaxants ☐ Flexeril ☐ Valium ☐ Xanax ☐ Ativan ☐ Librium ☐ Other_____

Sleep medication ☐ Ambien ☐ Restoril ☐ Benadryl ☐ Halcion ☐ Other _____

Anti-depressants ☐ Elavil (amitriptyline) ☐ Pamelor (nortriptyline) ☐ Prozac ☐ Effexor ☐ Desipramine ☐ Zoloft ☐ Restoril ☐ Paxil ☐ Serzone ☐ Remeron ☐ Other _____

Narcotics ☐ Vicodin ☐ Darvocet ☐ Tylenol #3 ☐ Codeine ☐ Percocet ☐ Percodan ☐ MS Contin ☐ Oxycontin ☐ Demerol ☐ Methadone ☐ Dilaudid

Neuropathic pain medication ☐ Neurontin (gabapentin) ☐ Lyrica (pregabalin) ☐ Klonopin ☐ Tegretol ☐ Dilantin ☐ Baclofen ☐ Ultram (tramadol) ☐ Prozosin ☐ Mexiletine

DIAGNOSTIC IMAGING

In order to receive the most benefit from this comprehensive consultation, please provide all radiographic studies including the radiology report as well as a CD of the films or the original films themselves (ie; MRIs, CT Scans, X-rays, EMGs, etc). Dr. Brown reads and interprets your diagnostic imaging / tests himself; please do not rely of other doctors or medical facilities to forward your records.

Please list the diagnostic imaging that you have previously had performed:

		Body part	Date	Imaging Center	Results
X-rays	☐ Yes ☐ No	_____	_____	_____	_____
MRI	☐ Yes ☐ No	_____	_____	_____	_____
CT Scan	☐ Yes ☐ No	_____	_____	_____	_____
Bone Scan	☐ Yes ☐ No	_____	_____	_____	_____
EMG	☐ Yes ☐ No	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

PAST MEDICAL HISTORY

Surgeries and/or hospitalizations?_____

_____

_____

Any problems with surgery or anesthesia? ☐ Yes ☐ No If yes, explain

_____

Please provide a list of your past and present medical problems:

_____

_____

Do you have a history of any of the following:

☐ **HIV** ☐ **Hepatitis B** ☐ **Hepatitis C**

Previous accidents?

Have you had any previous motor vehicle accidents? ☐ Yes ☐ No

If yes, were you injured? ☐ Yes ☐ No Did you seek medical attention or treatment? ☐ Yes ☐ No

Details of care/treatment_____

Have you had any work related injuries? ☐ Yes ☐ No

If yes, did you seek medical attention or treatment? ☐ Yes ☐ No

Details of care/treatment_____

Other accidents and injuries?_____

REVIEW OF SYSTEMS

Please check all that apply

General ☐ Recent weight loss ☐ Recent weight gain ☐ Fatigue ☐ Fever ☐ Change in apetite

☐ Night sweats

Skin ☐ Rashes ☐ Lumps ☐ Itching ☐ Dyrness ☐ Color change ☐ Hair or nail change

Head ☐ Headaches ☐ Head injuries ☐ Dizziness

Eyes ☐ Glasses ☐ Contacts ☐ Pain ☐ Double vision ☐ Redness ☐ Glaucoma

Date of last exam _____/_____/_____

Nose ☐ Frequent colds ☐ Nasal stuffiness ☐ Hay fever ☐ Nosebleeds ☐ Sinus trouble ☐ Dust/animal allergies

Ears ☐ Hearing loss

Mouth & Throat Date of last exam _____/_____/_____ ☐ Bleeding gums ☐ Frequent sore throats ☐ Hoarseness

Neck ☐ Goiter ☐ Lumps/swollen glands ☐ Pain

Breasts Date of last mammogram _____/_____/_____ ☐ Lumps ☐ Pain ☐ Nipple discharge

Cardiovascular ☐ Chest pain/angina ☐ Heart disease ☐ MI (heart attack) ☐ Congestive heart failure

☐ High blood pressure ☐ Peripheral vasular disease ☐ Abnormal heartbeat ☐ Pacemaker ☐ Angioplasty

☐ Rheumatic fever ☐ Damaged heart valve ☐ Hypercholesterolemia ☐ DVT (deep vein thrombosis)

☐ Palpitations ☐ Swelling of feet ☐ Shortness of breath

Peripheral Vascular ☐ Leg cramps while walking ☐ Varicose veins ☐ Thrombophlebitis

Neurological ☐ Epilepsy/seizure ☐ Fainting spells with dizziness ☐ Stroke ☐ Headaches ☐ Fainting ☐ Blackouts
☐ Weakness ☐ Numbness ☐ Tremors ☐ Tingling in hands or feet ☐ Change in memory

Gastrointestinal ☐ Ulcers ☐ Heaburn/reflux ☐ Diverticulitis/colitis ☐ Bowel incontinence ☐ Gallbladder disease
☐ Diarrhea ☐ Constipation ☐ Abdominal pain ☐ Hemorrhoids
☐ Jaundice (skin or whites of eyes turning yellow ☐ Other_____

Genitourinary ☐ Frequent urinary tract infection ☐ Benign prostate hypertrophy ☐ Prostate cancer ☐ Stones
☐ Episodes with urination ☐ Urinary incontinence ☐ Sexual transmitted disease ☐ Frequent uination
☐ Painful urination ☐ Blood in urine ☐ Difficulty urinating or difficulty holding urination
☐ Waking up to go to the bathroom several times at night

Respiratory ☐ Asthma ☐ Shortness of breath ☐ Emphysema ☐ Tuberculosis ☐ Pulmonary embolism
☐ Current smoker _____ packs per day ☐ Past smoker: quit _____years ago, smoked _____ packs per day

Metabolic ☐ Diabetes ☐ Thyroid disease ☐ Adrenal gland problems ☐ Steroid use

Liver/Kidney/Blood ☐ Kidney disease ☐ Shunt ☐ Graft / Fistula ☐ Dialysis ☐ Liver disease ☐ Gallbladder
☐ Anemia ☐ Hepatitis / type_____ ☐ Easy bruising/bleeding ☐ Blood transfusions / years_____
☐ Anticoagulants/blood thinners

Musculoskeletal ☐ Rheumatism ☐ Any rheumatologic disease ☐ Arthritis/osteoperosis ☐ Fractures ☐ Arthritis
☐ Joint stiffness ☐ Gout ☐ Muscle pains ☐ Muscle cramps

Autoimmune ☐ Rheumatoid arthritis ☐ Polymalgia/rheumatica ☐ Lupus ☐ Scleroderma ☐ Other_____

Psychological ☐ Depression ☐ Anxiety ☐ PTSD ☐ Panic/anxiety attacks ☐ Phobias
☐ Previous or curent psychiatric care ☐ Other _____

Abuse Have you ever been hit, slapped, kicked or otherwise physically hurt by someone? ☐ Yes ☐ No
Were you hurt in the past year? ☐ Yes ☐ No Were you hurt prior to this year? ☐ Yes ☐ No
Has anyone ever forced you into having any type of sexual activity? ☐ Yes ☐ No

Endocrine ☐ Heat intolerance ☐ Cold intolerance ☐ Excessive sweating ☐ Excessive hunger ☐ Excessive urination

Cancer ☐ Yes ☐ No Type?_____

Anything else in your past medical history? _____

SOCIAL HISTORY:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Employed ☐ Unemployed ☐ Social Security Disability ☐ Workers compenstation disability

If you are not currently, when did you last work?_____

What type of work do you do?_____

Do you have children? ☐ Yes ☐ No Number of girls? _____ Number of boys? _____

How many live at home? _____

Your education level

High school ☐ 10 ☐ 11 ☐ 12

College ☐ 1 ☐ 2 ☐ 3 ☐ 4

Graduate school ☐ Yes

SUBSTANCE ABUSE HISTORY:

How many drinks containing alcohol do you have on an average week? _____

Have you ever been concerned about your drinking? ☐ Yes ☐ No ☐ Not sure

Has a friend, family member or healthcare worker ever been concerned about your drinking or suggested you cut down?

☐ Yes ☐ No ☐ I'm not sure

Do you smoke? ☐ Yes ☐ No

If yes,

How many cigarettes do you smoke per day? _____

How old were you when you started smoking? _____

Have you ever tried to quit? ☐ Yes ☐ No

Are you interested in quitting? ☐ Yes ☐ No

If a former smoker, how long ago did you quit? _____

Please check any substances you have used (even if only once)?

☐ Marijuana ☐ Cocaine ☐ Crystal meth ☐ Heroin ☐ Opiates (oxycontin, vidodin, etc

☐ Ecstacy/mushrooms/LSD ☐ Other _____

When was the last time you used? _____

Have you EVER injected any type of substance? ☐ Yes ☐ No

FAMILY HISTORY (Please check all that apply):

☐ Stroke ☐ Heart disease ☐ High blood pressure ☐ Thyroid disease ☐ Diabetes ☐ Kidney disease ☐ Asthma

☐ Arthritis ☐ Osteoperosis ☐ Migraine headaches ☐ Alcoholism ☐ Depression ☐ Anxiety

☐ Cancer / what type_____

GYNECOLOGIC HISTORY:

☐ Not applicable due to gender

Have you ever had a hysterectomy? ☐ Yes ☐ No Why?_____

When?_____

Were both ovaries removed? ☐ Yes ☐ No Was 1 ovary removed? ☐ Left ☐ Right

Menopause? ☐ Yes ☐ No If yes, please skip next 5 lines

Date of last period _____/_____/_____ Frequency of periods? (eg, every 28 days) _____

Check all that apply

☐ Related headaches ☐ Weight gain ☐ Swelling ☐ Cramps ☐ Anxiety ☐ Depression

☐ Other _____

Are you currently taking birth control? ☐ Yes ☐ No

IF APPLICABLE:

Age at menopause? _____ Have you ever taken estrogen replacement? ☐ Yes ☐ No

If yes, what was the name of the estrogen replacement? _____

What age was estrogen replacement started? _____ How long was it used? _____

Have you ever taken progesterone? ☐ Yes ☐ No

Please check all of the following symptoms of menopause you are experiencing?

☐ Hot flashes ☐ Fatigue ☐ Anxiety ☐ Depression ☐ Insomnia ☐ Irregular bleeding

PLEASE BRING THESE COMPLETED FORMS WITH YOU TO YOUR INITIAL CONSULTATION WITH DR. BROWN. THANK YOU AND WE LOOK FORWARD TO MEETING WITH YOU.