

Name:

Acct #:

Date:

ROBERT E. ATKINSON, M.D.

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Date: \_\_\_\_\_

FOR OFFICE USE

XRAY:

WC/NF:

DOI:

CL #:

ADJ:

EMPLOYER:

Primary Care Physician: \_\_\_\_\_

Referred by: \_\_\_\_\_

1. What is your chief symptom or problem: \_\_\_\_\_

2. Location of pain/problem: \_\_\_\_\_

3. What factors make pain/problem worse? \_\_\_\_\_

4. When did pain/problem start (date)? \_\_\_\_\_

5. Please rate the severity or intensity of pain (circle number):

0	1	2	3	4	5	6	7	8	9	10
Mild			Moderate					Severe		

6. The pain is present: Constantly\_\_ Intermittently\_\_ At night\_\_

7. The quality of pain is: Sharp\_\_ Dull\_\_ Burning\_\_ Other\_\_

8. How did symptoms/condition start? \_\_\_\_\_

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**Systems Review - Please answer "yes" or "no". If answer is "yes" describe type of problem:**

	YES	NO	TYPE
1. Recent cold or flu?	_____	_____	_____
2. Recent skin problems?	_____	_____	_____
3. Recent eye/ear problem?	_____	_____	_____
4. Recent nerve problem?	_____	_____	_____
5. Recent depression/anxiety?	_____	_____	_____
6. Recent respiratory problem?	_____	_____	_____
7. Recent heart problem?	_____	_____	_____
8. Recent intestinal problem?	_____	_____	_____
9. Recent urinary problem?	_____	_____	_____
10. Recent bleeding problems?	_____	_____	_____

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Name: \_\_\_\_\_

Acct #: \_\_\_\_\_

Date: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

SUPPLEMENTS (e.g. St John's Wort, Ginseng, Creatine): \_\_\_\_\_

PREVIOUS SURGERY (with dates if known): \_\_\_\_\_

**Past History: Please answer "yes" or "no"**

	YES	NO
High blood pressure	_____	_____
Coronary artery disease	_____	_____
Heart attack	_____	_____
Irregular heart beat	_____	_____
Stroke	_____	_____
Asthma	_____	_____
Emphysema	_____	_____
Tuberculosis	_____	_____

	YES	NO
Ulcer	_____	_____
Intestinal bleeding	_____	_____
Hepatitis	_____	_____
Kidney failure	_____	_____
Diabetes	_____	_____
Seizures	_____	_____
Hypothyroidism	_____	_____
Cancer	_____	_____

If "yes" describe type: \_\_\_\_\_

**Family History: Please answer "yes" or "no"**

	YES	NO
Diabetes	_____	_____
Thyroid disease	_____	_____
Stroke	_____	_____
Anemia	_____	_____
Hepatitis	_____	_____

	YES	NO
Cancer	_____	_____
Heart disease	_____	_____
High blood pressure	_____	_____
Kidney disease	_____	_____
Bleeding disorder	_____	_____

**Social History:**

Sports, Exercise: \_\_\_\_\_

Occupation or School: \_\_\_\_\_

Do you smoke? Yes \_\_\_ No \_\_\_

# \_\_\_ packs per day

Do you drink ALCOHOL? Yes \_\_\_ No \_\_\_

# \_\_\_ packs per day \_\_\_ week \_\_\_ month

**Physical:**

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Right handed \_\_\_

Left handed \_\_\_