Patient Name: _____ Date: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Welcome to our office! We are honored that you have chosen us as your healthcare providers. Although we are aware how annoying it is to fill out these forms, we pride ourselves on being meticulous when it comes to your health. Please understand that we have two primary concerns: 1) Your health and 2) Our reputation! Please be as precise as you can. Your accuracy helps our accuracy.

Which physician referred you to this office?_____
May we share this data with them? (Y N)

HISTORY FORM- Current History

1. Chief Complaint: What is bothering you today?

_____

This problem began when and how?

_____

Have you had this pain before?

_____

Please circle the Quality of the complaint/pain:
dull aching sharp shooting burning throbbing deep nagging other (specify) _____
Does this complaint/pain radiate or travel (shoot) to any areas of your body? (Y N)
Where?_____
Do you have any numbness or tingling in your body? Where?

_____

How frequently are you experiencing this? And, how long does it last?

_____

Is your complaint getting better, getting worse, or is it unchanged since it began?

_____

Is there any daily activity you have difficulty with or can no longer do?

_____

Does the pain or discomfort interrupt your sleep? (Y N)
Does anything, for sure, aggravate the complaint? (i.e.: a particular position or activity.)

_____

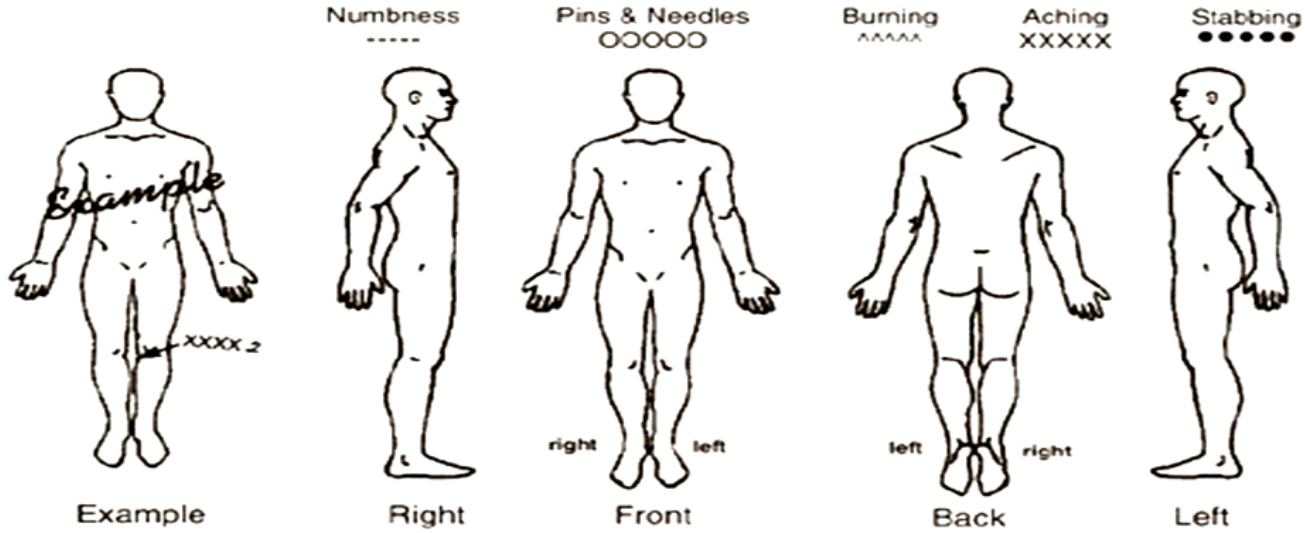
Does anything make the pain or discomfort better? (i.e. ice, heat, rest, special chair.)

_____

How has the current condition affected your ability to function at:
Home: _____
Work: _____
Exercise: _____
Social Activities: _____
Have you noticed any significant changes in your current constitution? Example: changes in weight, bowel habits, nausea, dizziness, ringing in the ears, balance issues or visual disturbances? (Y N)
If yes, please describe: _____
Overall, aside from this problem, how would you say your overall health is? _____
What is your occupation?_____

The illustration below is known as a visual analogue scale. It is our way of attempting to truly understand your current issues. Can you please illustrate your symptoms on the body graphs indicating the intensity of the pain or discomfort, at its worst on a 1 to 10 scale. One is "no pain-no problem" ☺. Five is a significant amount of pain but you can bear it 😐. Ten is the worst possible pain where hospitalization will most likely be required, tears are shed, and if pain persists for long, ideas of suicide might enter the picture ☹.

Please mark **area(s)** of injury or discomfort as shown below in the example.



Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

1 2 3 4 5 6 7 8 9 10

Previous remedies, treatments, medications, surgery, or care you've sought or tried for THIS complaint:

_____

2. Past History:

Previous illnesses you've had in your life:

_____

Previous injury or fractures:

_____

Allergies

_____

Medications:

Medication Dosage Reason for taking

_____

_____

_____

Surgeries:

_____

_____

3. Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family: Parents/ Siblings

Cause of parents or siblings death — Age at death

_____ _____

_____ _____

_____ _____

4. Social and Occupational History:

What are the physical demands of your job?: _____

What are the physical demands of your Recreational activities: _____

Sleeping position: _____

Lifestyle (level of exercise, alcohol, tobacco and drug use, diet):_____

_____

5. Medical Condition History

Please circle any of the following conditions *you have had in the past or present*. You may circle more than one condition.

Alcoholism
Anxiety
Asthma
Arthritis-rheumatoid
Arthritis-osteo, degenerative
Blood Clot Yr_____
Blood Transfusion Yr_____
Bone Infection
Bowel disease
Cancer (specify) _____
Congestive Heart Failure
COPD (chronic obstructive pulmonary disease)
Depression
Diabetes
Elevated Cholesterol
Fibromyalgia
Gerd/acid reflux
Gout
Heart Attack Yr _____
Heart Disease
Hepatitis – Liver Disorder
High Blood Pressure
Hypothyroidism
Irregular heart rate
Kidney Disease
Liver Disorder-Cirrhosis
Lung Disease
Osteopenia/Osteoporosis
Parkinson's
Stroke
Ulcer Disease
Other (specify all others)

6. Review of Systems

Please circle all problems you currently experience. You may circle more than one answer for each category.

General:
recent weight gain
recent weight loss
appetite change
difficulty sleeping

Cardiovascular:
chest pain
heart attack
palpitations (irregular heart beat)
edema (leg swelling)
leg cramps w/walking

Hematopoietic / Lymphatic:
low blood counts
lymph node enlargement
bleeding problems
frequent infections

Gastrointestinal:
heartburn / indigestion
difficulty swallowing
stomach pains
ulcers
nausea / vomiting
diarrhea
hemorrhoids
rectal bleeding
black bowel movements
change in bowel habits
constipation
frequent laxative use
jaundice or hepatitis
liver trouble
gallbladder problems

Psychiatric:
anxious feelings
depressive feelings
seen by a psychiatrist

Genitourinary:
burning on urination
frequency of urination
difficulty starting urine
wetting pants or bed
bloody urine

Respiratory:
shortness of breath
cough
sputum
bronchitis
night sweats

Musculoskeletal:
joint pain
joint swelling or warmth
joint stiffness
muscle pain
weakness
back pain
joint deformity

Neurologic:
headaches
dizziness
blackouts
numbness and tingling
paralysis
convulsions / seizures
coordination troubles

Your Personal Reasons for Care and Personal Goals

People attend care for a variety of reasons and there are different levels of care. Please check the type of care you are most interested in pursuing so that the doctors can make recommendations based on your desires.

Stage 1 ___ Pain relief: Just get rid of the pain, Doc! Relief is short-term.

Stage 2 ___ Rehabilitation: Get rid of the pain, Doc, but then fix this problem so that it doesn't come back!

Stage 3 ___ Optimal Health: Get rid of the pain, fix the problem, and then put me on a pro-active plan which may include: diet, exercise and periodic care so that I can reach and maintain my optimal health and life potential.

Patient Declaration: I have answered all of these questions truthfully and to the best of my knowledge.
Patient Signature: _____ Date _____

Automobile or Worker's Compensation Accident Questionnaire

(You may ignore this form if you are NOT here because of an accident.)

Name: _____ Today's Date _____

Date of Accident: _____ Location: _____ **Time:** ____:____ **AM/PM**
Your Car Insurance Co. _____ **Policy#** _____ **Claim#** _____
Other Vehicle Car Ins. _____ **Policy #** _____ **Claim#** _____
If Worker's Comp: Did you fill out an accident report on the job? (Y N)
Did you inform your supervisor of the injury? (Y N) Name: _____ **date** _____
Did your employer file his report of the accident? (Y N)
Have you been given a "panel of three" doctors from which you MUST choose one? (Y N)
Have you been referred by the "panel" doctor? (Y N) Name of Referring Doctor: _____
Your Vehicle: Make _____ Model _____ Year _____
Other Vehicle: Make _____ Model _____ Year _____
Were You: 1) The driver 2) The Passenger 3) Right Rear Passenger 4) Left Rear Passenger
Were you wearing your seat belt? (Y N) (If anything other than a shoulder-lap belt, please specify)
Did the airbags deploy? (Y N) Which ones? _____
Where was your vehicle hit? 1) Front 2) Rear 3) Lt. Side 4) Rt. Side
Did your vehicle roll? (Y N) Spin? (Y N) Strike another vehicle or object? (Y N) _____
Did any part of your body come into contact with any part of the interior of your vehicle? If yes, identify areas. _____
Did you lose consciousness at any time? (Y N) If yes, for how long? _____
Did you see or anticipate the accident? (Y N) If yes, did you feel yourself tense? _____
Please describe the car accident or the circumstances of the Worker's Comp claim:

_____
_____
_____
_____

Please Circle the part of body that was injured: 1) Head 2) Neck 3) Shoulder 4) Arm
5) Elbow 6) Wrist 7) Hand 8)Upper Back 9) Lower Back 10) Knee 11) Ankle 12) Foot
Did your symptoms develop: 1) Immediately 2) A few hours later 3) Next Day 4)After a few days
Did you receive medical aid at the site of the accident? (Y N) Require an Ambulance? (Y N)
Where did you go after the accident? 1) Hospital 2) Emergency Room 3) Home 4) Work 5) To this office
Name of Hospital: _____
What treatment did you receive? _____
What is the estimated cost of damage to the vehicle you were in? _____
Are your current injuries interfering with your job performance? (Y N) How?_____
_____
Are your current injuries interfering with your lifestyle? (Y N) How? _____

Lawyer's Name: _____ **Phone:** _____
Address: _____

NOVA HEADACHE & CHRONIC PAIN CENTER 703-425-5550
8993-A Cotswold Drive
Burke, VA 22015

Patient's Signature:_____ Date: ___/___/_____

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