SIMEDHealth

Name: _____ MR#:_____Date: _____

Date of Injury: _____ Referred By: _____

Age: _____ Date of Birth: _____ Handed: □ R □ L □ Ambidextrous □ Male □ Female

**** Mark appropriate squares □: (Made add comments in open lines)**

If you mark "YES" explain on line **

Main Reason (Complaint) for Today's Visit: (In your own words) _____

_____

Briefly Describe Accident or Development of Present Complaint: _____

_____

_____

_____

Are Symptoms Related to an Accident or Trauma?: □ N/A □ Yes □ No Date: _____

If related to motor vehicle accident:

Were you the driver? □ Yes □ No Were you wearing a seat belt? □ Yes □ No

Were you □ Stopped □ Moving At what speed were you travelling? _____

Were you hit □ Head On □ Driver's Side □ Passenger's Side □ Rear of Vehicle At speed ____MPH

Did you have loss of consciousness? □ Yes □ No If yes, for how long? _____

Was airbag deployed? □ Yes □ No Did you go to the emergency room? □ Yes □ No Hospital: __

Complaint's Characteristics:

When did symptoms start? (Date) _____How did symptoms start? □ Gradual □ Sudden

Are symptoms □ Continuous □ Intermittent (Off and On)

Are symptoms □ Mild □ Moderate □ Severe Pain Scale (0-10): _____

Pain characteristic: □ Dull □ Sharp □ Burning □ Tooth-ache like □ Stabbing

□ Pressure Like □ Throbbing □ Other: _____

Does *pain refer* to other areas? □ Yes □ No Where? _____

What makes the symptoms worse? □ N/A □ Sitting □ Standing □ Walking □ Lying Down

□ Lifting □ Bending □ Twisting □ Coughing □ Driving

What makes the symptoms better? _____

Associated Symptoms:

Do you have *Numbness*? □ Yes □ No Where? _____

Do you have *Tingling*? □ Yes □ No Where? _____

Do you have *Weakness*? □ Yes □ No Where? _____

Do you have symptoms at *Night*? □ Yes □ No Where? _____

Do you have problems *Urinating*? □ Yes □ No Explain _____

Do you have *Bowel Function* problems? □ Yes □ No Explain _____

Do you have *Sexual Dysfunction*? □ Yes □ No Explain _____

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Name: _____ MR#:_____Date: _____

Are symptoms: □ Increasing □ Decreasing □ Remain about the same

What treatments have you tried? □ Medications □ Physical Therapy □ Chiropractic Care □ Surgery □ Injections □ Electrical Stimulation □ Braces/Cane □ Acupuncture □ Other: _____

By whom (or where) have you been treated for this problem? _____

Primary Care Physician: _____ Attorney: _____

Pharmacies used in the last two years (name and city): _____

What tests have you had for this problem? □ Myelogram □ MRI □ CAT Scan □ Electrodiagnostic Studies □ Bone Scan □ Arthrogram □ X-Ray □ Other: _____

Your Past Medical History: Mark appropriate squares □ : (May add comments in open lines)

Diabetes	□ Yes	□ No	On Blood Thinner	□ Yes	□ No
Thyroid Disease	□ Yes	□ No	Kidney Disease	□ Yes	□ No
Arthritis	□ Yes	□ No	HIV / AIDS	□ Yes	□ No
Heart Disease	□ Yes	□ No	Stroke	□ Yes	□ No
High Blood Pressure	□ Yes	□ No	Polio	□ Yes	□ No
Pace Maker	□ Yes	□ No	Lung Disease	□ Yes	□ No
Vascular Disease	□ Yes	□ No	Sleep Apnea	□ Yes	□ No
Cancer	□ Yes	□ No	Depression / Bipolar	□ Yes	□ No
Ulcers	□ Yes	□ No	Schizophrenia	□ Yes	□ No
Liver Disease	□ Yes	□ No	Prior Suicide Attempt	□ Yes	□ No
Glaucoma	□ Yes	□ No	Seizures	□ Yes	□ No
Tuberculosis	□ Yes	□ No	Gastric band/bypass	□ Yes	□ No

□ Other: _____

Do you have a history of substance abuse? □ Yes □ No □ N/A □ Quit When? _____

If history of substance abuse, please explain: When? What substance(s)? For how long? Any Treatments? _____

Have you ever been denied care or released by any healthcare providers because of violations to their drug policies? □ Yes □ No Where & When? _____

Any history of arrests or convictions due to illegal substances or alcohol issues? □ Yes □ No

Habits: Do you smoke? □ Yes □ No □ Quit How much? _____

Do you drink alcohol? □ Yes □ No □ Quit How much? _____

List surgeries or operations: _____

_____

List other injuries or accidents in past: _____

List current medications: (Including over the counter medications): _____

_____

List medications tried in the past for this problem: _____

_____

List medication allergies: □ None _____

List any medical problems ***in your family:*** _____

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Name: _____ MR#:_____Date: _____

Check your current status: □ Married □ Single □ Divorced □ Separated □ Widow

Hobbies: _____

Your work history: Occupation: _____ Education level / Training: _____

Describe your job: _____

Place of work: _____ Are you still working? □ Yes □ No

Last Worked: (Date) _____ How many hours per week? _____ Any Restrictions? □ Yes □ No

Do you receive? Disability Check □ Yes □ No Worker's Comp Check □ Yes □ No

ROS: Check "□" for active symptoms or "O" for prior inactive symptoms. Leave blank absent symptoms.

*Fever	□ / O	*Short of Breath	□ / O	*Weakness	□ / O	*Depression	□ / O
Chills	□ / O	Cough	□ / O	Joint Pain	□ / O	Anxiety	□ / O
Weight Loss	□ / O	Sputum	□ / O	Joint Swelling	□ / O	Irritable	□ / O
*Blurred Vision	□ / O	*Nausea	□ / O	Pain in Back	□ / O	Decreased Sleep	□ / O
*Headache	□ / O	Vomiting	□ / O	Joint Stiffness	□ / O	*Night Sweats	□ / O
Hearing Loss	□ / O	Blood in Stool	□ / O	Muscle Cramps	□ / O	Heat Intolerance	□ / O
Hard to Swallow	□ / O	Diarrhea	□ / O	*Rashes	□ / O	Cold Intolerance	□ / O
Nasal Stuffiness	□ / O	Stomach Pain	□ / O	Nipple Discharge	□ / O	*Bruise Easily	□ / O
*Chest Pain	□ / O	*Pain when urinating	□ / O	*Seizures	□ / O	Allergies	□ / O
Palpitations	□ / O	Discharge from genitals	□ / O	Memory Loss	□ / O	*Current Infection	□ / O
*Recent Fractures	□ / O	*Other: _____					

Are you pregnant? □ Yes □ No □ Estimated Due Date: _____

Do you have problems with self-care or mobility issues? □ Yes □ No (Mark that apply)

□ Eating □ Bathing □ Toileting □ Dressing □ Getting up from laying or sitting position

□ Walking

Patient's Signature: _____ **MD Initials:** _____

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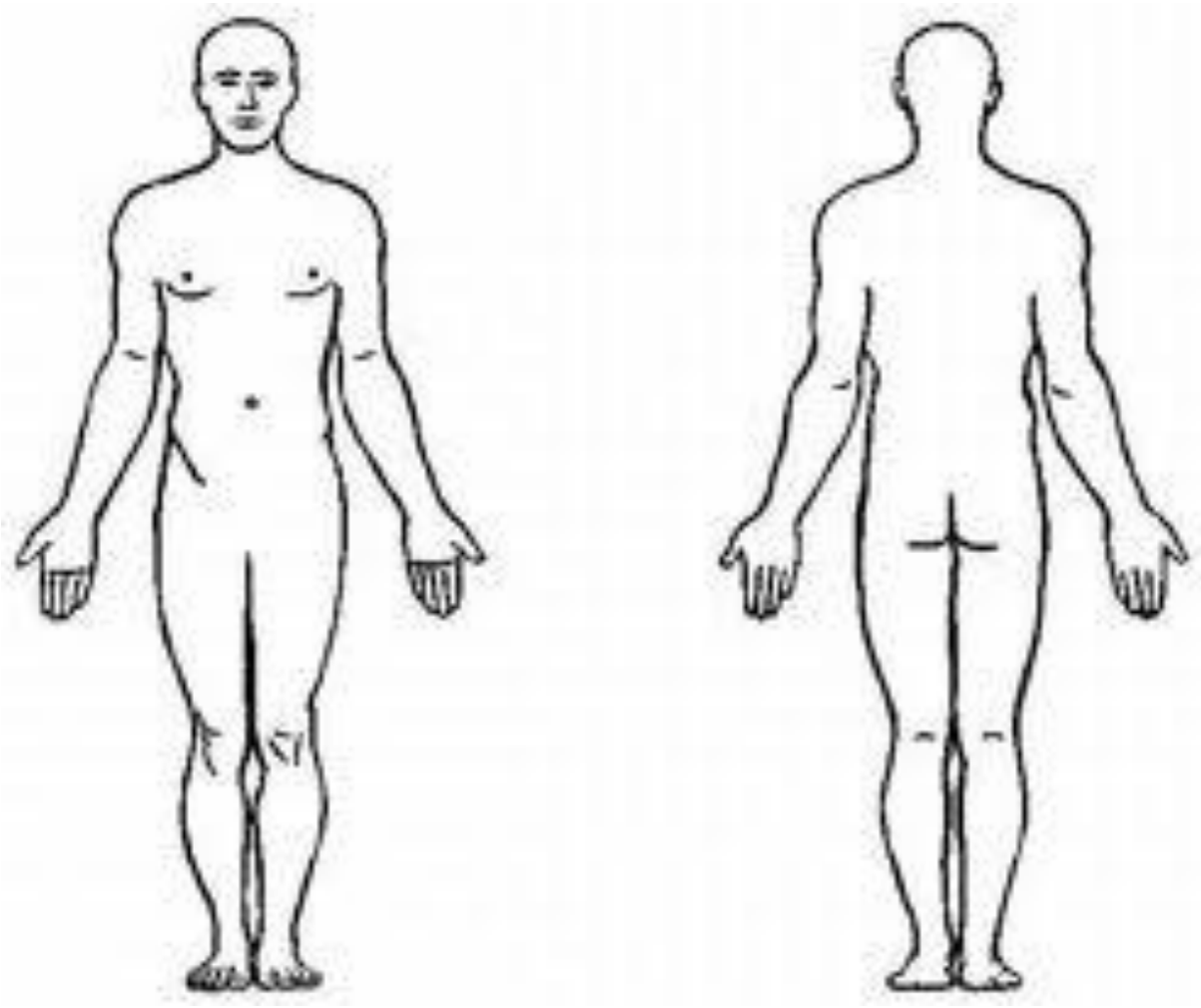

Patient Name: _____

Date: _____

Medical Record#: _____

Please indicate where your problem is.