



S PINE INSTITUTE of Arizona

Patient Name: _____

Date: _____

This form must be filled out at each office visit.

We are required to have documentation of medications and allergies for each office visit; because of this we are unable to accept "no change" or "same as before" answers on this form.

Medications currently taking	Dosage	Frequency
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1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

Allergies:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

Pharmacy:

Name: _____

Address: _____

Phone: _____

EMG Pain Diagram

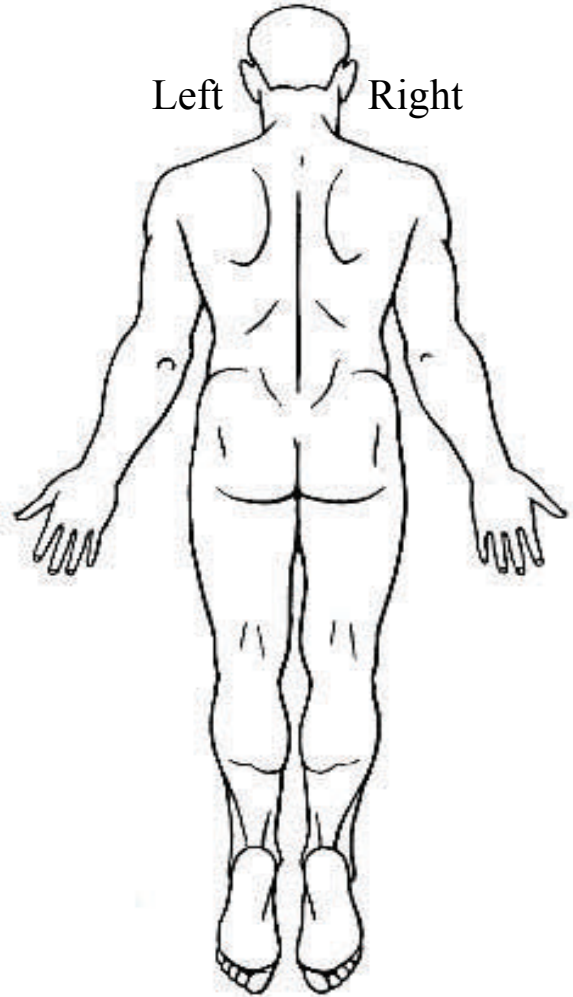
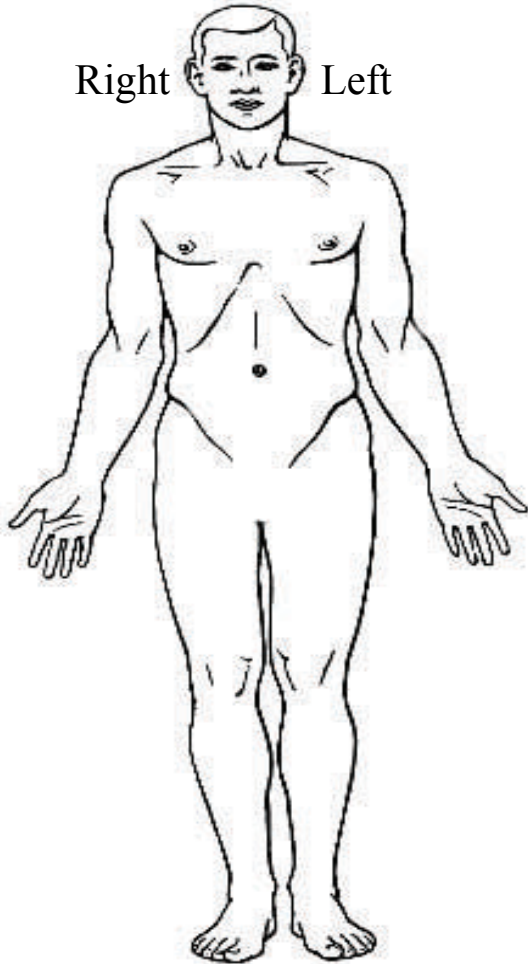


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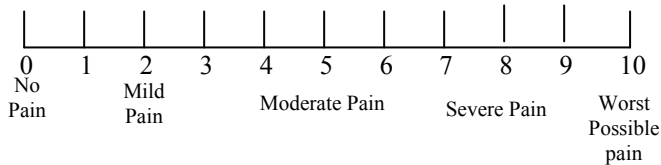
Patient Name: _____

Date: _____

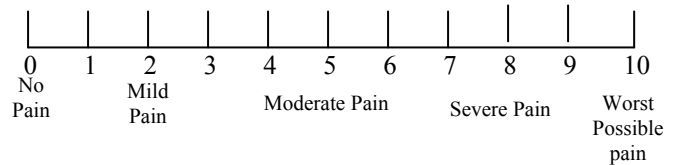
Please mark an "X" on the body part(s) where you have pain.
Mark a "0" on the body parts where you have numbness.



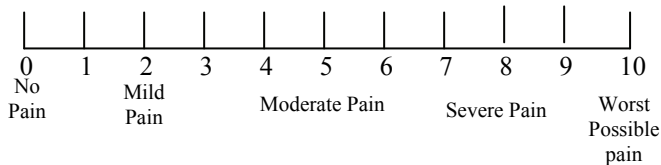
NECK



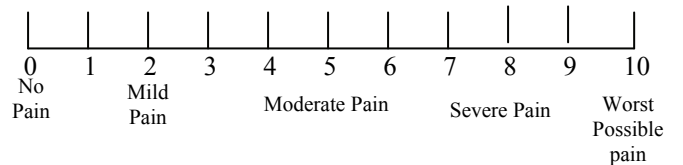
BACK



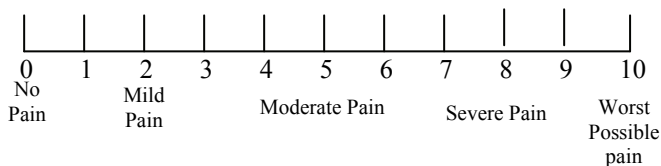
RIGHT ARM



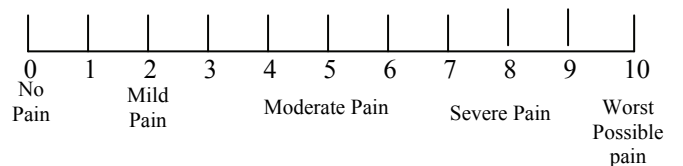
RIGHT LEG



LEFT ARM



LEFT LEG



REVIEW OF SYMPTOMS

In the past month, have you experienced any of the following?

Please put a check mark in front of any/all of the following that you have experienced.
If you have experienced any of the symptoms, please be sure to notify your family doctor.

H.E.E.N.T.

- Blurred vision
- Dry Eyes
- Hard of hearing
- Nasal Congestion
- Sore Throat
- Cough
- Other _____

PULMONARY

- Shortness of breath
- Other _____

ABDOMINAL

- Abdominal Pain
- Other _____

INTEGUMENTARY

- Moles
- Skin Rash
- Other: _____

NEUROLOGIC

- Tremors
- Other: _____

GASTROINTESTINAL

- Abdominal Pain
- Other _____

CARDIOVASCULAR

- Chest Pain
- Other _____

GENERAL

- Fevers
- Chills
- Night Sweats
- Stress
- Poor sleep
- Swelling of feet
- Swollen glands
- Problems with blood clots
- Weight Loss
- Weight Gain
- Other _____

PAST MEDICAL HISTORY:

(Please circle any/all of the following that you have experienced.)

- | | | |
|--------------------------|-------------------|--------------------------|
| AIDS | Depression | Heart Attack/Angina |
| Anemia | Diabetes | Hepatitis C |
| Anxiety Problem | Diverticulosis | High Blood Pressure |
| Arthritis | Ear Trouble | HIV |
| Asthma | Endometriosis | Irregular Heart Beat |
| Bipolar Disease | Enlarged Prostate | Irritable Bowel Syndrome |
| Cancer | Fibromyalgia | Jaundice |
| Colon Polyp | Gastritis | Kidney Disease |
| Congestive Heart Failure | Glaucoma | Kidney Stones |
| COPD/Emphysema | Gout | Liver Disease |
| Deep Venous Thrombosis | Head Injury | Lupus |

Other Medical Problems: _____