MARION BLOCH
NEUROSCIENCE INSTITUTE

ABOUT YOU (Please print clearly)

Name_________________________________ Birth Date ______________ Age_____
Sex: Male__Female__ Referring MD __________________________________
Mailing Address:________________________ Address ____________________________________
_________________________________ ____________________________________
Home phone number____________________ MD Phone number______________________________
Work number___________________________ Any other MD you request we send information to?
Employer______________________________ -if so name, address and phone _________________
Employer address________________________ ____________________________________

PATIENT HEALTH HISTORY

CHIEF COMPLAINT: What specifically brings you to see the physician today?

____
____
____
____

HISTORY OF PRESENT ILLNESS:

1. Describe present symptoms: Location, severity, onset and duration.

____
____

If you have pain or numbness or other sensory changes, please mark the areas on the next page and answer the following questions that apply to you:

O Morning O Later in the day O During the night O Always the same

What activities worsen your symptoms?

O Arm overhead O Lifting O Riding and/or driving a car O Sneezing O Straining bowels
O Climbing stairs O Sitting O Movement of the neck/back O Standing O Walking
O Coughing O Other____

Have changes occurred in your bladder, bowel, or sexual function? O YES O NO
If YES, please describe: ____

2. Describe how it happened or what you think caused it:

____
____

3. When did the symptoms begin? Month and date.____________________________
4. If injury / accident related, date of injury / accident: _________________________
5. Is this injury related to work? O YES O NO O UNCERTAIN
6. Have you filed a Workers' Compensation claim? O YES O NO
7. Is this injury related to an auto accident? O YES O NO
8. Is a lawsuit in progress or being planned? O YES O NO
9. Please list tests you have already had:

O MRI O CT O Myelogram O Discogram O Regular Spine X-rays
O Bone Scan O EMG O Angiogram O Other

10. Please list all other physicians and chiropractors who you have seen for this problem and treatments that have been performed:

DATE	PHYSICIAN	TREATMENTS	LOCATION

11. Have you been in physical therapy? O YES O NO

DATE	FREQUENCY	DATE ENDS	LOCATION

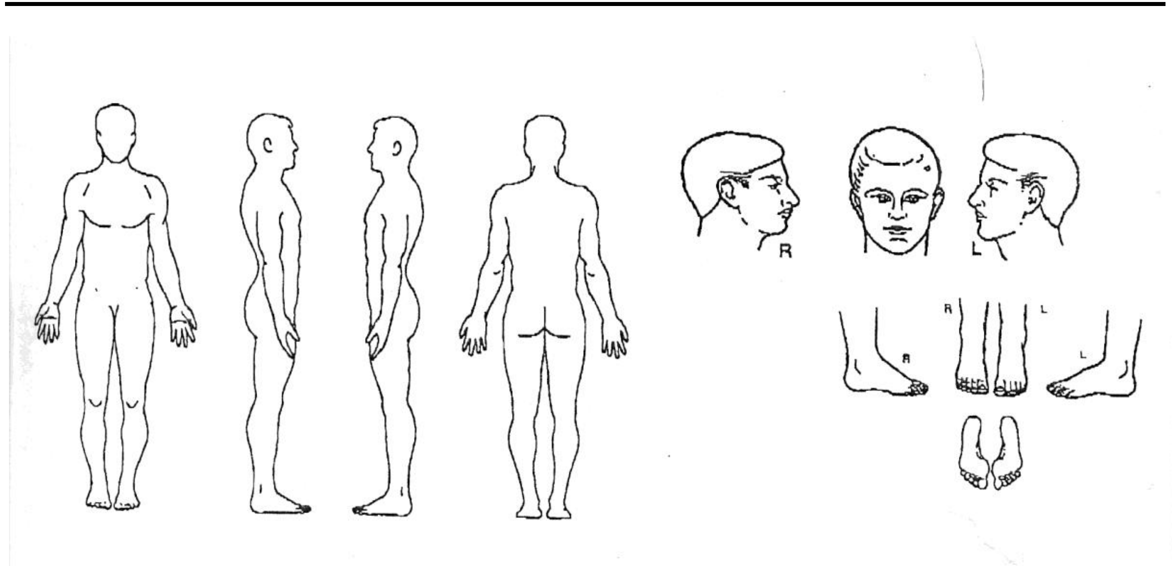
12. What (other) treatments have you already had (injections, acupuncture, previous spinal surgery)?

____
____

SENSATION DRAWING

Where is your pain now? Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

Face pain	Neck pain	Arm pain	Back pain	Leg pain	Total Score=
______%	______%	______%	______%	______%	= 100%
SYMPTOM=	Ache	Numbness	Pins / Needles	Burning	Radiating Pain
SYMBOL=	^^^^^^^^	000000000	==========	xxxxxxx	///////////////////



How bad is your pain?

On a scale of 0 to 10 (0 = no pain, 5 = moderate, 10 = worst pain)

At its very worst 0 1 2 3 4 5 6 7 8 9 10

Now 0 1 2 3 4 5 6 7 8 9 10

Overall, is your pain generally: O Improving O Same O WORSENING?

PAST MEDICAL HISTORY. List significant illnesses or hospital stays without surgery.

____
____
____
____
____
____
____
____
____

Are you a diabetic? O YES O NO

SURGERY AND HOSPITALIZATION HISTORY. List ALL previous surgeries and hospitalization, include dates and physicians names.

____
____
____
____
____
____
____
____
____
____
____

If you are a female
are you pregnant? O YES O NO How many pregnancies? ____ How many births? ______

FAMILY HISTORY:

		Current Age or Age at Death	Health Problems or Cause of Death
FATHER:	O Alive O Deceased	___________________	___________________
MOTHER:	O Alive O Deceased	___________________	___________________

	Number	Ages	Serious Illnesses	Number Deceased / Cause
Sisters:	______	_______	___________________	______________________________
Brothers:	______	_______	___________________	______________________________
Daughters:	______	_______	___________________	______________________________
Sons:	______	_______	___________________	______________________________
Spouse:	______	_______	___________________	______________________________

Do you know of any blood relative who had had the following illnesses: If yes, check all that apply and provide relationship to patient?

O Aneurysm_________________ O Chiari Malformation_________ O Lung Disease________________
O Brain Hemorrhage_________ O Diabetes____________________ O Seizures___________________
O Brain Tumor______________ O Heart Disease________________ O Stroke______________________
O Cancer____________________ O Spinal Disease________________

NEUROSURGERY SERVICES:

CURRENT MEDICATIONS. Please complete the medication list below with the medications you are currently taking. If you have difficulty completing this form, please bring your medication with you to your appointment. Include name, dose, and frequency.

Medication:	Dose	How often you take it?
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___

ALLERGIES. Include medications, foods, tapes, latex. Include what adverse reaction you experience.

___

___

___

Do you wear a prosthesis, pacemaker, or metal implant? O YES O NO

If yes, please specify. ___

Are you claustrophobic (having fears or anxiety in a confined environment, i.e. MRI)? O YES O NO

SOCIAL HISTORY AND HABITS:

1. O Married. O Divorced. O Single. O Widow / Widower. O Significant Other.
2. Who lives with you?
___
3. If you have surgery, who can help you when you go home from the hospital?
___
4. Do you smoke? O YES O NO If so, how much? ___ ___pack per ___
   Did you ever quit? O YES O NO. IF so, when did you quit? ___
   Are you interested in assistance with quitting? O Medication O Self help
5. Are you exposed to second hand smoke? O YES O NO
6. Do you use alcohol? O YES O NO If so, how much? ___ When did you quit? ___
7. Do you use and “street” drugs? O YES O NO If so, how frequently? Did you ever use any? ___
8. Are you retired? O YES O NO
9. Are you employed? O YES O NO If so, where? O Full Time O Part time O Disabled since___
   Present and / or former occupation___
   Describe the type of work you do (i.e. lifting, standing, sitting).

___

___

   How many years have you done this job?

___

   Have you lost work due to this current injury? ___ Last date worked___

NEUROSURGERY SERVICE REVIEW OF SYSTEMS:
Please check those times that pertain to you during your lifetime.

ALLERGIES
- ☐ Asthma
- ☐ Hay fever
- ☐ Other ________________

CARDIOVASCULAR
- ☐ Heart attack
- ☐ Heart surgery
- ☐ Stents
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Difficulty breathing at night
- ☐ Heart Murmur
- ☐ Irregular heart beat
- ☐ Pacemaker
- ☐ Poor circulation
- ☐ Swollen legs or feet
- ☐ Varicose veins
- ☐ Other__________________

EARS/NOSE/THROAT
- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Hoarseness
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Disease/injury
- ☐ Glaucoma
- ☐ Hearing Loss
  - o Right o Left

ENDOCRINE
- ☐ Diabetes
- ☐ Excessive hunger/ thirst
- ☐ Intolerance to warm room
- ☐ Loss of libido
- ☐ Multiple broken bones
- ☐ Rapid weight gain
- ☐ Rapid weight loss
- ☐ Spontaneous nipple discharge
- ☐ Thyroid problems
- ☐ Other__________________

Patient Signature:

____

EYES
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Eye infections
- ☐ Vision flashes or halos
- ☐ Eyeglasses/contacts
- ☐ Other__________________

GENERAL
- ☐ Chills/sweat/fever
- ☐ Difficulty sleeping
- ☐ Headache
- ☐ Recent fatigue
- ☐ Recent weight gain
- ☐ Recent weight loss

GASTROINTESTINAL
- ☐ Black stools
- ☐ Blood in stools
- ☐ Chronic diarrhea
- ☐ Heartburn/ acid reflux
- ☐ Hepatitis A,B,C (circle one)
- ☐ Increasing constipation
- ☐ Liver disease
- ☐ Nausea
- ☐ Vomiting
- ☐ Other__________________

GENITOURINARY
- ☐ Difficulty to initiate/retention
- ☐ Discharge from penis/vagina
- ☐ Kidney Stones
- ☐ Incontinence (loss of urine)
- ☐ Prostate problem
- ☐ Urgency
- ☐ Urinary Tract infection
- ☐ Painful urination
- ☐ Other__________________

HEMOTOLOGIC
- ☐ Easy skin bruising
- ☐ Marked fatigue
- ☐ Prolonged bleeding
- ☐ Tender glands/lymph nodes
- ☐ Other__________________

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Muscle tenderness
- ☐ Muscle spasms
- ☐ Muscle weakness
- ☐ Joint swelling in
  - o Hands o Hips
  - o Wrists o Knees

MOOD
- ☐ Anxiety
- ☐ Depression
- ☐ Panic attacks
- ☐ Restlessness
- ☐ Other__________________

RESPIRATORY
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Coughing of blood
- ☐ Night sweats
- ☐ Short of Breath
- ☐ Tuberculosis (TB)
- ☐ Asthma/Wheezing
- ☐ Other__________________

NEUROLOGICAL
- ☐ Fainting
- ☐ Headaches
- ☐ Numbness of arms or legs
- ☐ Problem with memory
- ☐ Confusion
- ☐ Stroke
- ☐ Seizures
- ☐ Head injury
- ☐ Tingling of hands/arms/legs
- ☐ Other__________________

SKIN
- ☐ Chronic skin itching
- ☐ Color changes of hands or feet in the cold
- ☐ Poor scarring/non-healing ulcer
- ☐ Skin rashes or hives
- ☐ Unusual moles
- ☐ Other__________________

LAST VISIT WITH
- ☐ Dentist________________
- ☐ Ophthalmologist_________
- ☐ Primary Care Doctor_______________