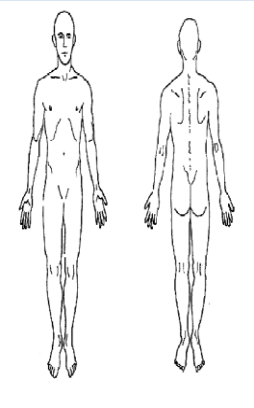
INITIAL EVALUATION

Name:		**Date of Visit:**	**Date of Injury:**	**Date of Birth:**
Insurance:		**Referred by:**	**Attorney:**	**PCP:**
Age:	**Sex: M / F**	**Requesting Company:** Premier Prizm /	**Claim Number**	**Is this IME: Yes / No Start: End:**

CHIEF COMPLAINTS: □(Circle all that applies)



Headaches Neck Pain □ Upper Extremity Pain (L / R) □ Upper Back Pain Chest Pain □ □
Low back Pain □Pelvic Pain □ Lower Extremity Pain (L / R) □ Foot Pain L/R) □ Facial Pain
Whole body pain Hip Pain (L / R) Shoulder Pain (L/R) Elbow pain (L/R) Wrist pain(L/R)
Multiple joints pain other _____

Pain characteristics are:

Intensity: _____10 (Today) **Duration**: (How Long ago it started) _____

Quality: Dull / Sharp / Shooting / Burning / Throbbing / Stabbing / Aching / knife like / Other _____

Aggravating factors: □ Physical activity □ Bending □ Twisting □ Lifting □ Walking Sitting □ Standing □

Relieving factors: □ laying down □ Physical Activity □ Medications _____

Associated Issues: □ Numbness _____□ Tingling _____

HISTORY OF PRESENT ILLNESS: How and when did your pain start? (Please describe)

_____

_____

_____

Is your pain related to an Injury? If yes (check) AUTO / Work Related / Slip and Fall Date of Injury _____

You were □ Driver / Passenger / Restrained (seat belt) / Unrestrained □/ Unconscious / Taken to Emergency by Ambulance

Rear Ended / Front ended / Side Impact **Is Claim still open** : Yes/ No / LOP **Were you working at the time of accident**: Yes / No

Describe what happened (INJURY) :_____

_____

Previous Injuries / **Preexisting conditions** to account for your pain _____

_____

TESTS PERFORMED: □ **X-Rays** □ **Bone Scan** □ **CAT Scan** (CT) □ **MRI** □**Myelogram** □**EMG** □ Other _____

1. _____ 2. _____

3. _____ 4. _____

PREVIOUS TREATMENTS: **Physical Therapy** (when) _____**Medications** _ _____

Chiropractic Care _____ / **Acupuncture** / **Pain Mx**: _____Injections (Epidural / Facet Block /

Sacroiliac / Selective Nerve Root Block / Discogram _____**Ortho /Surgery** _____**PCP**_____

INITIAL EVALUATION

PAGE 2:
Patient Name _____

ALLERGIES: □ **No Allergies** / Allergy to IV Dye / Iodine / Shell fish / sea food / **Medications** _____

CURRENT MEDICATIONS: List your current medications / See attached list

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Are you taking blood thinners □ Aspirin □ Coumadin □ Plavix Pradaxa

PAST MEDICAL HISTORY (Please Check all that applies) □

Diabetes / Hypothyroid / Hyperthyroid / Heart Disease / Hypertension / Stroke □/ Lungs disease / HIV / AIDS □/Hepatitis
Depression / Anxiety / Bipolar / Psychosis / Kidney Disease □ Cancer _____ □ _____

Neck Pain / Mid-back pain / Low back pain / Fibromyalgia / Arthritis / Rheumatoid Arthritis / Multiple sclerosis / Shingles
Last Menstrual Period (Females) _____ □ **Are you Pregnant** (Females) No / Yes _____

PAST SURGICAL HISTORY:

Spine Surgery Cervical / Thoracic / Lumbar _____Spinal Cord Stimulator / Intrathecal Pump _____
Heart Surgery Lung Surgery □ Appendectomy □ Hysterectomy □ Gall Bladder Tonsillectomy
Joint Replacement (Hip / Knee / Shoulder Right / Left) _____ Other _____

SOCIAL HISTORY: (Please mention and mark yes or no and how much)

Marital Status: Married / Single / Divorced / Widowed **Smoke** (yes /no) _____PPD **Alcohol** (yes/No) _____ Illicit Drugs (yes/no)

Occupation: Working as _____Not working / Disabled (due to) _____

FUNCTIONAL HISTORY:

Activity of Daily Living □ Independent □ Dependent _____ **Ambulation** □ Independent □ Dependent with _____

FAMILY HISTORY: Please tell us age, disease suffering, alive or diseased

Father: Alive / Deceased / _____ Mother: Alive / Deceased_____

REVIEW OF SYSTEM: ***All the systems were reviewed and Positive findings are checked below***
If you are experiencing any of the following symptoms currently please check the symptom

GENERAL: □ Fever □ weight loss □ Weight Gain □ Chills □ Dizziness □ Night Sweats □Swollen Lymph Glands
SKIN: □ Bruises □ Itching □ Rash □ Hair loss □ Excessive hair growth
HEENT □ Vision Changes sore throat
BREAST: □ Swelling □ Lumps □ Pain □ Tenderness
LUNGS: □ Coughing □ Shortness of breath □ Wheezing
CARDIAC □ Fluttering Skipping □ Pounding □ Chest Pain
GASTROINTESTINAL □ Nausea Vomiting **Diarrhea** □ **Constipation**
URINARY: □ Blood in urine □Frequency of urine □ Burning while urinating
BOWEL: □ Loss of control
BLADDER: □ Loss of control Hesitancy Frequency
NERVOUS SYSTEM □ Seizures □ Weakness □ **Numbness** □ **Tingling** □ **Headaches** □ Dizziness □ Loss of consciousness
PSYCHIATRY: Depression □ Suicidal ideas □ Anxiety □ Memory loss **Insomnia**
SEXUAL: □ Impotency □ difficulty with erection □ loss of interest
MUSCULOSKELETAL Soreness □ Fractures Sprain □ Swelling □ Stiffness

Other _____