David S. Weingarden, M.D. & Associates, P.C.

Name: _____ **DOB:** _____

PLEASE COMPLETE AND ANSWER ALL QUESTIONS

Is the **Main Problem** that you are coming to us for?			
Your Personal Doctor's Name & Address:			
Sex: ☐ Male ☐ Female	Is your **Referring** Doctor, Dr.		
Marital Status:	You are: ☐ Right Handed ☐ Left Handed		
How many children do you have?	Employer:	Your Occupation:	
Their ages are:	Years at Present Employer:	Date last worked:	

- List **ALL MEDICINES**, **VITAMINS** or **HERBAL PREPARATIONS** you currently take:

- List **ALLERGIES** and the **REACTION - OR** check box if ☐ **No Known Allergies**

- Do you have any **MEDICAL PROBLEMS**? ☐ No ☐Yes (If Yes, Please List Them)

- If you answer **Yes** to any of the following questions please provide details and year of occurrence.

Have you ever had a(n)?		Details (please list year and type)
• **INJURY / ACCIDENT**	☐ No ☐ Yes	
• **BROKEN BONE**	☐ No ☐ Yes	
• **OPERATION**	☐ No ☐ Yes	
• **EMOTIONAL OR NERVOUS PROBLEM**	☐ No ☐ Yes	

- Have you ever been an **Alcoholic?** ☐ No ☐ Yes **Addictive drug user**? ☐ No ☐ Yes
- Have you ever been the victim of **Abuse**? ☐ No ☐ Yes

If yes, a. Was the abuse? ☐ Physical ☐ Emotional ☐ Psychological ☐ Sexual

b. At what stage(s) in your life did this occur? ☐ Adult ☐ Teenager ☐ Child

Name: Date of Birth

- **Do You Have Any of the Following Problems? Please be sure to answer <u>each question</u>**

Difficulty With Your Ability To:		
- Hear	☐ Yes	☐ No
- See	☐ Yes	☐ No
- Speak	☐ Yes	☐ No
- Swallow	☐ Yes	☐ No
- Smell	☐ Yes	☐ No

Pain in Any of the Following Areas			**Side**
- Head	☐ Yes	☐ No	☐ R ☐ L
- Neck	☐ Yes	☐ No	☐ R ☐ L
- Shoulders	☐ Yes	☐ No	☐ R ☐ L
- Upper Back	☐ Yes	☐ No	☐ R ☐ L
- Chest	☐ Yes	☐ No	☐ R ☐ L
- Arms	☐ Yes	☐ No	☐ R ☐ L
- Elbows	☐ Yes	☐ No	☐ R ☐ L
- Forearms	☐ Yes	☐ No	☐ R ☐ L
- Wrists / Hands	☐ Yes	☐ No	☐ R ☐ L
- Fingers	☐ Yes	☐ No	☐ R ☐ L
- Mid Back	☐ Yes	☐ No	☐ R ☐ L
- Stomach	☐ Yes	☐ No	☐ R ☐ L
- Low Back	☐ Yes	☐ No	☐ R ☐ L
- Pelvic Area	☐ Yes	☐ No	☐ R ☐ L
- Hips	☐ Yes	☐ No	☐ R ☐ L
- Thighs	☐ Yes	☐ No	☐ R ☐ L
- Knees	☐ Yes	☐ No	☐ R ☐ L
- Shins / Calves	☐ Yes	☐ No	☐ R ☐ L
- Ankles	☐ Yes	☐ No	☐ R ☐ L
- Feet	☐ Yes	☐ No	☐ R ☐ L
- Toes	☐ Yes	☐ No	☐ R ☐ L

Problems with any of the following:		
- Diabetes	☐ Yes	☐ No
- Weight Loss / Gain	☐ Yes	☐ No
- Fever / Night Sweats	☐ Yes	☐ No
- Mouth / Throat	☐ Yes	☐ No
- Breathing / Asthma	☐ Yes	☐ No
- Heart/Circulation/Blood Pressure	☐ Yes	☐ No
- Heart racing/pounding in chest	☐ Yes	☐ No
- Stomach Acid/ Gas/ Reflux	☐ Yes	☐ No
- Ulcers	☐ Yes	☐ No
- Irritable Bowel Syndrome	☐ Yes	☐ No
- Diarrhea / Constipation	☐ Yes	☐ No
- Hemorrhoids	☐ Yes	☐ No
- Endometriosis	☐ Yes	☐ No
- Impotency / Kidney Problems	☐ Yes	☐ No
- Arthritis	☐ Yes	☐ No
- Cancer	☐ Yes	☐ No
- Memory	☐ Yes	☐ No
- Headaches / Migraines	☐ Yes	☐ No
- Seizures	☐ Yes	☐ No
- Shakes / Tremors	☐ Yes	☐ No
- Weakness	☐ Yes	☐ No
- Nervousness / Anxiety	☐ Yes	☐ No
- Depression	☐ Yes	☐ No
- Thyroid	☐ Yes	☐ No
- Hormones	☐ Yes	☐ No
- Glaucoma	☐ Yes	☐ No
ALL OTHER SYSTEMS ARE NEGATIVE ?	☐ Yes	☐ No

- Do you have a **Family History** of any of the following: Please check all that apply

☐ Alcoholism	☐ Severe Nervousness	☐ Cancer
☐ Emotional Problems	☐ Problems similar to yours	☐ Heart Disease
☐ Psychiatric Problems	☐ Arthritis	☐ Being on Disability
☐ Diabetes	☐ Any others:	

- When did you last use **Tobacco** / **Smoke**? ☐ Never ☐ Today ☐ _____
  If you use/smoke or have used/smoked, for how many years? ____ On average, how many per day_____

- Do you have any **Hobbies** or Participate in Any **Exercise or Sports Programs?** (Please list them)

- What is the date your main problem first started? _____

- Did you ever have a problem like this before? ☐ No ☐ Yes
  If Yes, when is the first time in your life you experienced it? _____

- **How** did your problem **Start**? ☐ Suddenly ☐ Gradually

- If you remember, what were you doing when this problem began? _____

_____

Name: Date of Birth

- Which **Doctors** have you seen for this problem :

- Which **Tests** have you taken for this problem?

TEST		Date of Test	Body Area Checked	Test Results
X-Ray ?	☐ No ☐ Yes			
CAT Scan ?	☐ No ☐ Yes			
MRI ?	☐ No ☐ Yes			
Myelogram ?	☐ No ☐ Yes			
EMG/Nerve Test?	☐ No ☐ Yes			
Bone Scan ?	☐ No ☐ Yes			
Blood Test ?	☐ No ☐ Yes			
Other Test ?	☐ No ☐ Yes			

- Which **Medicines** have you taken for this problem?

MEDICINE	% RELIEF	RELIEF LASTS HOW LONG?	MEDICINE	%RELIEF	RELIEF LASTS HOW LONG?

- Which **Treatments** have you had for this problem? (Check all that apply)

☐ Physical Therapy ☐ TENS Unit ☐ Cortisone Injections ☐ Braces / Support Garments
☐ Nerve Blocks ☐ Cane or Walker ☐ Exercise Programs ☐ Other: _____

- Which word(s) best **Describe your pain**:

☐ SHARP ☐ PICKING ☐ ACHING ☐ TOOTH-ACHEY ☐ NAGGING
☐ STABBING ☐ LIGHTNING ☐ BORING ☐ DULL ☐ SORENESS
☐ BURNING ☐ CATCHING ☐ PRESSURE ☐ OTHER:

- Which things **make** your pain **worse**: _____

- Which things **ease** or **relieve** your **pain:** _____

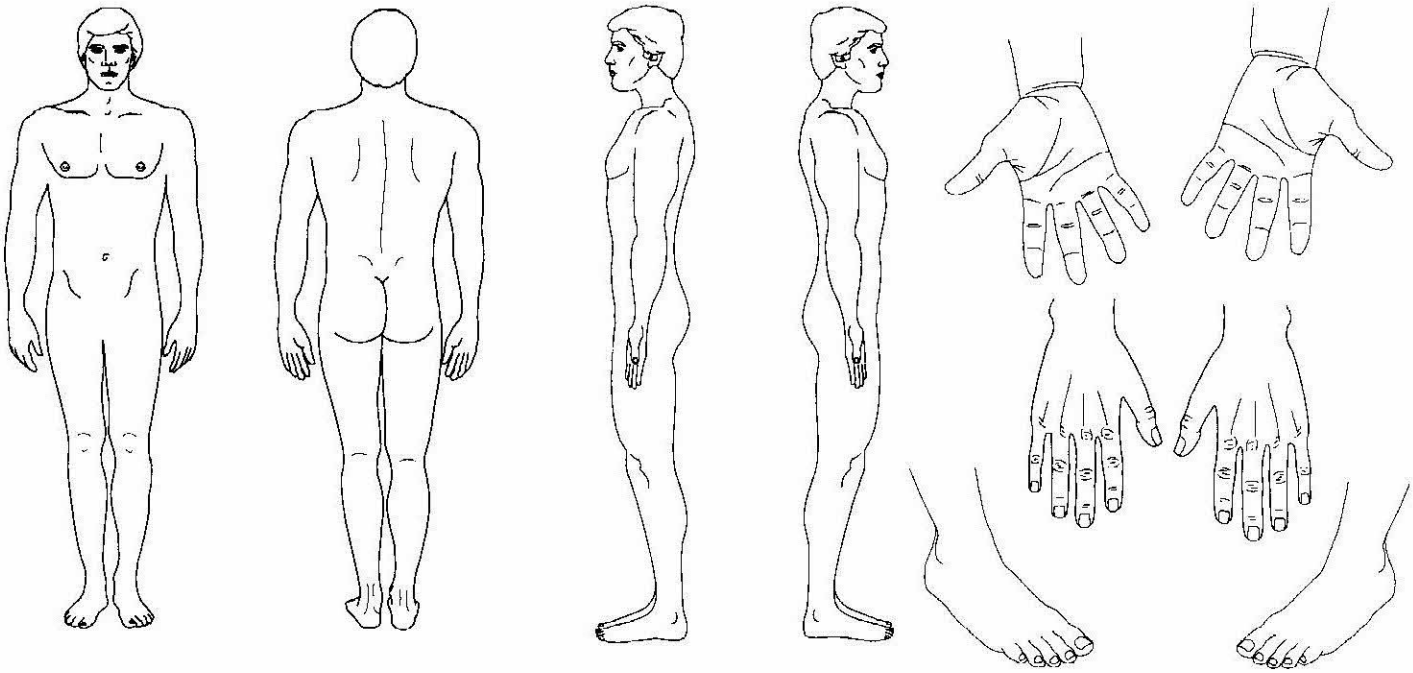
- Is your Pain: ☐ Constant ☐ Worse in the AM ☐ Worse in the PM ☐ Waking you up

Name: Date of Birth

- Do you have problems with any of the following?

☐ Numbness or Tingling	☐ Loss of Control of Your Bowels	☐ Abdominal Pain
☐ Pins & Needles Sensations	☐ Recent Change in Your Bowel Habits	☐ Weakness
☐ Burning Sensations	☐ Blood in Your Urine or Stool	☐ Difficulty Falling Asleep
☐ Loss of Appetite	☐ Problems with Sexual Function	☐ Difficulty Staying Asleep
☐ Leakage of Your Bladder	☐ Recent Weight Loss or Weight Gain	

Please Draw Your Areas of Pain and Trouble with the following key: **Pain = xxxx**
Numbness = oooo



- Is your pain or trouble the same from day to day? ☐ Yes ☐ No If No, in the past week, how many good days did you have? _____ and how many bad days did you have? _____
- Using a scale of 1 to 10, 0 = "no pain", 1 = "just barely there", and 10 = "worst pain you could ever imagine", please answer the following questions.
  1. What number is your pain today? _____
  2. On a **Good Day**, what number is your pain when you **first get up**? _____
  3. On a **Good Day**, what number is your pain **at the end** of the day? _____
  4. On a **Bad Day**, what number is your pain when you **first get up**? _____
  5. On a **Bad Day**, what number is your pain **at the end** of the day? _____
- What is your height? _____/Ft _____/In What is your weight? _____/Lbs

INSTRUCTIONS: The next questionnaire will help us to better understand your problems. It may be necessary to ask you more questions about some of these items.

The following box is ONLY regarding issues you experienced in the PAST MONTH! Please make sure to check a box for every item.

During the **PAST MONTH**, Have you been bothered **A LOT** by……						During the **PAST MONTH**.....		
	Yes	**No**		**Yes**	**No**		**Yes**	**No**
S								
1. Stomach pain	☐	☐	13. Nausea, gas, or indigestion	☐	☐	21. Have you had an anxiety attack (suddenly feeling fear or panic)	☐	☐
2. Back pain	☐	☐	14. Feeling tired or low energy	☐	☐			
3. Pain in your Arms, Legs, or Joints	☐	☐	15. Trouble sleeping	☐	☐	22. Have you thought you should cut down on your drinking of alcohol	☐	☐
4. Menstrual pain or problems	☐	☐	16. Your eating habits being out of control	☐	☐			
5. Pain or other problem during intercourse	☐	☐				23. Has anyone complained about your drinking	☐	☐
6. Headaches	☐	☐	M 17. Little interest or pleasure in doing things	☐	☐	24. Have you felt guilty or upset about your drinking	☐	☐
7. Chest pain	☐	☐						
8. Dizziness	☐	☐	18. Feeling down, depressed, or hopeless	☐	☐	25. Was there ever a single day in which you had five or more drinks of beer, wine or liquor	☐	☐
9. Fainting spells	☐	☐						
10. Feeling your heart pound or race	☐	☐						
			A 19. "Nerves", or feeling anxious or on edge	☐	☐			
11. Shortness of breath	☐	☐						
12. Constipation, loose bowels, or diarrhea	☐	☐	20. Worrying about a lot of different things	☐	☐			

NAME & SIGNATURE: _____ DATE: _____