New Patient Information Form
Ian Wattenmaker, M.D.

Name: _____ Today's Date: _____

Height: _____ Weight: _____ Sex: M F Date of Birth: _____

Referring Doctor: _____ Age: _____R L Handed

1. Which best describes the reason for your visit today. List location on line (e.g., low back, hand, neck, leg, etc.)
(Place number, e.g., 1, 2 in order of severity)

   Pain ___ Numbness ___ Tingling ___

   Weakness ____ Spinal Deformity ___ (Scoliosis) Other ___

2. When did this problem begin?
   _____

3. Did it begin spontaneously or was there a specific injury? (Circle One)(If injury, please describe)
   _____
   _____

4. Have you had prior similar symptoms in the past? Y N
   If Yes: Date of Most Recent Symptoms _____Date of Initial Episode _____

5. Is the pain mild, moderate or severe? (Circle One)

6. Has your condition improved, deteriorated or remained the same since the episode began?
   _____

7. What makes your symptoms worse? (Circle All That Apply)

   Sitting Standing Bending Forward Walking None of the Above
   Other _____

8. What treatment have you received for this episode? (Circle All That Apply)

Physical Therapy	Anti-Inflammatories	Chiropractic Care
Oral Steroids	Epidural Steroid Injections	Muscle Relaxants
Surgery	Pain Medications	Other _____

9. Is your pain worse when you are trying to sleep compared to the pain during the day? Y N

10. Have you personally had cancer of any type? Y N

11. Have you ever had problems with anesthesia? Y N

    If yes, describe _____

DO NOT WRITE IN THIS AREA

CC:

ASSOC:

FEVERS:

CHILLS:

SPHINCTER FXN: NOR ABN

PATIENT NAME: _____**DATE:** _____

Medication (List All Taken)DoseReason for Medication

_____

_____

_____

_____

Allergies:

Surgeries/HospitalizationsYear

_____

_____

_____

_____

Past Medical History
Review of Systems

Have you ever had problems with your:

	Circle	Describe All Yes Responses
Eyes	Y N	_____
Ears, Nose, Throat	Y N	_____
Digestive Problem	Y N	_____
Bladder or Prostate Problem	Y N	_____
Diabetes	Y N	_____
High Blood Pressure	Y N	_____
Heart Disease	Y N	_____
High Cholesterol	Y N	_____
Kidney Disease	Y N	_____
Bleeding Problems	Y N	_____
Hepatitis or Liver Disease	Y N	_____
Depression	Y N	_____
Cancer	Y N	_____
Arthritis	Y N	_____
Lungs or Breathing Problems	Y N	_____
Seizures or Neurologic Problems	Y N	_____

Family History

Significant Family History: _____
_____

PATIENT NAME: _____DATE: _____

Social History

__ Employed (Occupation: _____) ___ Student ___ Retired
__ Single __ Married __ Divorced __ Widowed

Children Y N If yes, #___

Exercise __ Daily __ Weekly __ Rarely

What Type of Exercise? _____

History of Substance Abuse? Y N What Type? _____

Smoke Currently? Y N If Yes, _____ packs per day for ___ years.

Quit Smoking? __ No __ This Year __>5 years __>10 years

Alcohol Consumption? __ Never __ Daily __1-2 Times Per Week __ Rarely

Patient Signature: _____ Date: _____

Reviewed By: _____, MD **Date: _____**