American Health Network
spine & sport care

Michael J. Simek, MD
501 W Schrock Rd | Ste 103 | Westerville, OH 43081
3823 Trueman Court | Hilliard, OH 43026
117 W High St | Ste 108 | London, OH 43140
P 614.794.5069 | F 614.797.4505
www.ohiospineandsport.com

NEW PATIENT INFORMATION

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Referring Doctor/Therapist: _____

☐ Self Referral (How did you find Dr Simek?) _____

Are you ... ☐ Right handed ☐ Left handed ☐ Ambidextrous

REASON FOR VISIT:

Location of your pain: ☐ Head ☐ Shoulder ☐ Mid Back ☐ Leg ☐ Ankle/Foot ☐ Wrist/Hand

☐ Neck ☐ Headaches ☐ Low Back ☐ Knee ☐ Hips/Buttocks ☐ Arm

HISTORY OF PRESENT ILLNESS:

Date of injury or symptom onset: _____

Type of injury:

☐ Sports Injury ☐ Job Accident ☐ Car Accident (*Were you the* ☐ *Driver or* ☐ *Passenger? Seat belted?* ☐ *No* ☐ *Yes*)

☐ Other (explain): _____

Please describe how you injured yourself: _____

_____

_____

Please describe your current symptoms: _____

_____

_____

Circle the number that corresponds to the severity of your pain on a scale of 0-10.

"0" means no pain and "10" is the worst pain you can imagine.

At it's worst:	0	1	2	3	4	5	6	7	8	9	10
At it's best:	0	1	2	3	4	5	6	7	8	9	10

Which of the following best describes the character of your pain:

☐ Continuous, steady, constant ☐ Throbbing ☐ Burning ☐ Superficial

☐ Rhythmic, periodic, intermittent ☐ Aching ☐ Tingling/numbness ☐ Deep

☐ Brief, momentary, transient ☐ Sharp ☐ Dull

What makes your pain worse? _____

What makes your pain better? _____

How long/far can you: Sit _____ Stand _____ Walk _____

Since your injury is your pain: ☐ Better ☐ Same ☐ Worse

If your pain is changed, what percentage? 10 20 30 40 50 60 70 80 90 100%

Have you had any loss of bowel or bladder control? ☐ No ☐ Yes

PREVIOUS TREATMENT:

Have you had treatment since your injury? ☐ No ☐ Yes Have you been to the ER for this? ☐ No ☐ Yes

Have you had any of the following tests or procedures performed?

X-Rays? ☐ No ☐ Yes MRI? ☐ No ☐ Yes Epidurals? ☐ No ☐ Yes

CT Scan? ☐ No ☐ Yes EMG? ☐ No ☐ Yes

Other (please explain) _____

Medical:

Dr. _____ Date of 1st visit _____ Last visit _____

Diagnosis given _____

Medications given _____

Treatment provided _____

Chiropractic: ☐ No ☐ Yes

Dr. _____ Date of 1st visit _____ Last visit _____

Diagnosis given _____

Has it helped? ☐ No ☐ Yes

Physical Therapy: ☐ No ☐ Yes

Therapist _____ Date of 1st visit _____ Last visit _____

Has it helped? ☐ No ☐ Yes Home exercise program given? ☐ No ☐ Yes

CURRENT MEDICATIONS:

Name	Dosage	How often do you take this per day?

MEDICATION ALLERGIES: ☐ No ☐ Yes

If yes, please list:

Name	Reaction

Are you allergic or had any reaction to iodine, shellfish, IVP dye, or contrast media? ☐ No ☐ Yes

REVIEW OF SYSTEMS:

Please mark those items which you currently experience:

General
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weakness
- ☐ Weight gain
- ☐ Weight loss

Head/Hearing & Vision
- ☐ Blurred vision
- ☐ Double vision
- ☐ Facial pain
- ☐ Headache
- ☐ Ringing in ears
- ☐ Vertigo/Dizziness
- ☐ Vision loss

Respiratory
- ☐ Asthma
- ☐ Cough
- ☐ Dyspnea/Shortness of Breath
- ☐ Recent infections
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Heart Murmur
- ☐ Leg swelling
- ☐ Syncope/fainting
- ☐ Irregular heartbeat/ palpitations

Gastrointestinal
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Black tarry stools
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Genitourinary
- ☐ Dysuria/painful urination
- ☐ Hematuria/blood in urine
- ☐ Urinary incontinence

Metabolic/Endocrine
- ☐ Cold intolerant
- ☐ Hair loss
- ☐ Heat intolerant

Neurological
- ☐ Difficulty walking
- ☐ Poor coordination
- ☐ Memory loss
- ☐ Muscle weakness
- ☐ Paresthesia/numbness/tingling
- ☐ Seizures
- ☐ Tremors

Psychological
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Skin
- ☐ Itchy skin
- ☐ Rash
- ☐ Skin infections
- ☐ Skin lesions

Hematologic
- ☐ Bleeding
- ☐ Bruising

PAST MEDICAL HISTORY:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
  type: _____
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Drug abuse
- ☐ High Cholesterol
- ☐ Fibromyalgia
- ☐ Obesity
- ☐ Hypertension/high blood pressure
- ☐ Heart attack
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peptic ulcer disease
- ☐ Renal/Kidney disease
- ☐ Seizure disorder
- ☐ Stroke
- ☐ Thyroid disease

PAST SURGICAL HISTORY:

Please list type of surgery and approximate date

- ☐ Spine Fusion (Cervical/Thoracic/Lumbar)
- ☐ Laminectomy (Cervical/Thoracic/Lumbar)
- ☐ Discectomy (Cervical/Thoracic/Lumbar)
- ☐ Hip Replacement (R/L)
- ☐ Carpal Tunnel Release
- ☐ Gastric Bypass
- ☐ Knee replacement (R/L)
- ☐ Rotator Cuff Repair (R/L)
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

FAMILY HISTORY:

Please check box for any medical condition that a blood relative has a history of:

- ☐ Alcoholism
- ☐ Arthritis
- ☐ Cancer
  ☐ type: _____
- ☐ Cardiovascular disease
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Drug abuse
- ☐ High Cholesterol
- ☐ Hypertension/High BP
- ☐ Liver disease
- ☐ Mental illness
- ☐ Muscle disease
- ☐ Parkinson's Disease
- ☐ Peripheral vascular disease
- ☐ Stroke
- ☐ Thyroid disease

SOCIAL HISTORY:

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ "Living together"
- ☐ Separated

Number of children

_____

Do you smoke?
☐ No ☐ Yes

Previous smoker
☐ No ☐ Yes

Do you drink alcohol?
☐ No ☐ Yes

Do you use recreational drugs?
☐ No ☐ Yes

What type/how often?

_____

Are you currently employed?
☐ No ☐ Yes

If yes, type of job

_____

Mark on the areas on your body where you feel the described sensations. Use the symbols listed.
Mark areas of radiating pain or numbness as well. Include all affected areas.

Numbness	Tingling	Burning	Stabbing/Sharp	Aching	Cramping
o o o	: : : :	X X X	/ / / /	^ ^ ^	☐ ☐ ☐