Atlantic Medical Physicians

Primary Care Injury Centers
1500 Allaire Avenue
Ocean, NJ 07712

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Medical Director
Board Certified

PHONE #: 732-988-6300
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Patient Name:_____ **Date:** _____

1. Describe what happened and what hurts:

_____

_____

_____

_____

_____

_____

2. Was your supervisor notified immediately? ☐ YES ☐ NO

If not immediately, when? _____

3. Did you continue working after you were injured? ☐ YES ☐ NO

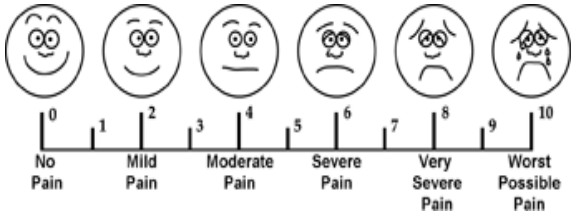
4. Did you go to the emergency room? ☐ YES ☐ NO

5. Were x-rays and/or MRI taken? ☐ YES ☐ NO

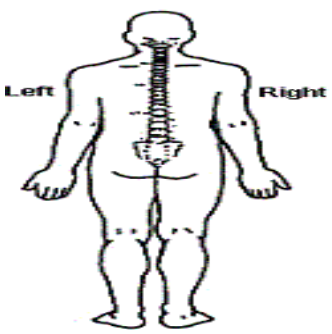
If yes, where? _____

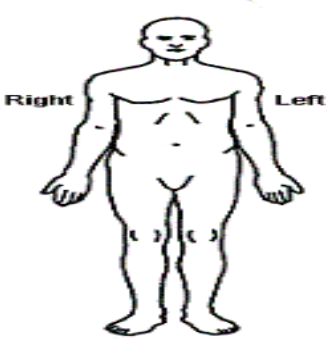
6. Rate your pain today on a scale of 1-10 _____

PAIN SCALE



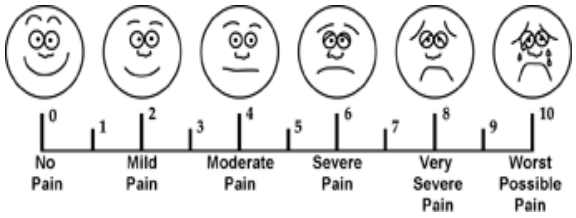
PAIN DIAGRAM:
Place X where you have pain
Place O where you are numb
Place Z where you are weak





7. Have you ever experienced symptoms similar in the past? ☐ YES ☐NO

8. If you answered yes, rate your preinjury pain on a scale of 1-10: _____



9. If yes, were they work related? ☐ YES ☐NO

10. How long have you been employed at your current job? _____

11. What is your current work status?

☐ FULL DUTY ☐ LIGHT DUTY ☐ OUT OF WORK

12. Have you ever been treated by a Chiropractor? ☐ YES ☐ NO

If yes, please provide name and address below:

Chiropractor name: _____

Address: _____

13. Have you ever been in a serious car accident? ☐ YES ☐ NO

If yes, please provide the date, injuries and treating provider:

_____

_____

_____

I hereby certify that all the information I have furnished on both pages of this form is true and correct:

Patient's Signature:_____ **Date:**_____

Reviewed By:_____ **Date:** _____

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Patient Name:_____ Date of Birth:_____ Age:____ Sex: ____

Name of Referring Doctor:_____ Name of Family Doctor: _____

Reason for today's visit: _____ _____

_____

_____

How long have you had this problem? *(Days, weeks, months, etc.)*_____

What makes it better or worse? *(Include any prior medical treatments, i.e. medications, physical therapy injections, etc.)* __ _____

_____

Rate the pain 0 (no pain) – 10 (worst imaginable pain) _____

Are you allergic to any drugs? *Circle one* YES or NO *If yes, please list those drugs below:*

Drug	**REACTION (i.e. rash, hives, palpitations, etc.)**	Drug	**REACTION (i.e. rash, hives, palpitations, etc.)**

List all current medications and dosages:

Past Medical History *(Please **circle** all that apply to you):*			Diabetes
High blood pressure	Coronary artery disease	Vascular disease	Emphysema
Heart disease/attacks	Congestive heart failure	Thyroid disease	Depression
Lyme disease	Bleeding disorder	Seizures	Gastric reflux
Multiple Sclerosis	Enlarged prostate	Hepatitis	Liver disease
Osteoarthritis	Rheumatoid arthritis	Stomach ulcers	Kidney disease
Asthma	COPD	Cancer	Scoliosis

Are you Pregnant: Yes_____ No_____

Please list any other medical conditions not mentioned above:_____

_____

Family History *(Please **circle** all that apply to members of your family):*			
Bleeding disorder	Coronary artery disease	Hepatitis	Cancer
Heart Disease/Attacks	Seizures	Lung disease	Rheumatoid arthritis
Kidney disease	Malignant hyperthermia	Scoliosis	Asthma

Please list any medical disease that a member of your family may have that is not mentioned above:

_____

Past Surgical History *(Please **circle** all that apply to you and list the date of surgery)*			
Surgery	Date	Surgery	Date
Knee arthroscopy (Right/Left)		Shoulder arthroscopy (Right/Left)	
Spine surgery (Neck/Back)		Joint replacement surgery	
Hernia repair		Laparotomy	
Eye surgery		Thyroid surgery	
Peripheral bypass surgery		Cardiac catheterization	
Coronary artery bypass graft		Hysterectomy	

Please list any other surgery you may have had in the past not mentioned : _____

_____

Ethnicity:_____Race:_____Primary Language: _____

Social History: *Please **circle** one:* Single / Married / Partnered / Widowed / Divorced

- Do you smoke?_____Current Smoker ____Former Smoker __ Never Smoked
  ___ Pipe Smoker ____Cigar Smoker
  If yes, how much do you smoke?_____3 cigarettes or less per day ____Half a pack per day
  ___ More than a pack per day
- Do you drink alcohol? YES NO
  If yes, how frequent? ____Social only ____Several times per week ____Everyday
- Do you or have you used illicit drugs? YES NO
  If yes, what kind?_____IV Drugs __ Pills ___ Marijuana ____Other

Education Level:_____Graduate Level ___College __ Some College __ HS Diploma __ Other

Occupation: _____

Sports Participation: Yes No
If yes, which sports? __Golf __Tennis __Football __Soccer __Baseball __Basketball __Run

List any other sports that you play: _____

*Please **circle** any of the following symptoms that you've experienced recently:*			
Constitutional	Fever	Night sweats	Weight loss
Eyes	Red eyes	Blurring vision	Vision loss
Ears/Nose/Mouth	Nose bleeds	Sore throat	Hearing loss
Cardiovascular	Chest pain	Palpitations	Leg swelling
Respiratory	Shortness of breath	Chronic cough	Wheezing
Gastrointestinal	Nausea	Vomiting	Diarrhea
Genitourinary	Burning w/urination	Blood in urine	Urinary incontinence
Skin	Rash	Hives	Skin infection
Neurological	Headache	Tremor	Seizures
Psychiatric	Depression	Panic attacks	Suicidal ideation
Endocrine	Excessive thirst	Cold intolerance	Excessive sweating
Hematological/Lymph	Easy bruising	Swollen glands	Easy bleeding
Allergy/Immune	Runny nose	Sinus congestion	Itchy eyes

Please describe in detail the symptoms and treatment you have related to the problems checked above: _____

_____

Patient Signature:_____ Date: _____

Reviewed by Physician:_____ Date: _____