Delaware Back Pain & Sports Rehabilitation Centers
Depend on us to get you better faster.

Date: ____-____-____
Patient ID #: _____
Name: _____
FK RH OM GW MT SM EH
FOR OFFICE USE ONLY

INITIAL HISTORY FORM
NEW EMG PATIENT

NAME: _____ DATE: _____

D.O.B: _____ Age: _____ Hand Dominance □ Right □ Left _____

Chief Complaint/Reason for Visit _____

How long has the pain (or your problem) been present? _____ years _____ months

Date of accident/injury _____

Were you injured in a motor vehicle accident (MVA)? □ yes □ no Was it a work related injury? □ yes □ no

What started the pain/problem? _____

What arm/leg has pain/weakness? □ **Right arm** □ **Right leg** □ **Left arm** □ **Left leg**

Are you having and neck pain? □ yes □ no Are you having any low back pain? □ yes □ no

List *ANY* medication that you take regularly (include prescription and non-prescription medications)

Medication Name	Date Started	Side Effects (if any)

Are you taking Coumadin, or any other blood thinners □ yes □ no

When did you take your last take the medicine? _____ PT INR _____

Do you have any allergies? □ No known drug allergies □ Yes (if yes select from below) □ latex □ paper tape

□ Aspirin □ Sulfa □ Novocaine/Lidocaine □ Iodine dye □ penicillin □ shellfish □ other_____

MEDICAL HISTORY - *Check all that apply to you*

□ **None apply**

□ **Diabetes**
□ **Hypertension**
□ **Heart Disease**
□ **High Cholesterol**
□ **Respiratory Problems**
□ **Stomach /Intestinal problems**
□ **Bleeding Disorders**
□ **Thyroid Problems**
□ **Inheritable Nerve Disease**
□ **Allergies**
□ **Kidney/Bladder/Prostrate Problems**
□ **Neurological Problems**
□ **Addiction or Substance Abuse**
□ **Mental Health/Psychiatric**
□ **Cancer**
□ **Chemotherapy**
□ **Radiation**
□ **Other medical diagnosis**_____
□ **Pacemaker**
□ **Defibrillator**
_____

PLEASE FILL OUT BOTH SIDES OF THIS FORM

* FOR OFFICE USE ONLY*

BP_____ Temp_____ Weight_____ Height _____

_____ _____
STAFF INITIALS DATE

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INITIAL HISTORY FORM
NEW EMG PATIENT

Past Surgical History ☐ No past surgical history

Surgery Type	Date/Surgeon

Have you ever had surgery on your neck or back? _____

Have you ever had surgery on your arms or legs? _____

Have you ever had any broken bones? _____

Family History Please check "yes" or "no". If "yes", please indicate which relative(s) have/had the problem.

Back problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Anesthesia problems	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No
Rheumatoid arthritis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Heart problems	☐ Yes ☐ No
Other	☐ Yes ☐ No

Social History

Are you currently ☐ single ☐ married ☐ widowed ☐ divorced ☐ separated

How many children do you have? _____Ages _____ How many live with you? _____

Do you smoke cigarettes? ☐ Yes ☐ No How many per day? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No frequency? _____