The Magnolia Clinic

Dr. George Del Villar

1318 E 6th Ave. Tallahassee, FL. 32303

To help us understand your problem, please complete **ALL QUESTIONS on ALL** of the attached forms.

Date_____.

Name_____**Age**_____**Date of birth**_____.

Height:_____**Weight:**_____**Eye Color:**_____**Tattoos**_____**Scars**_____.

Who referred you to us?_____.

Family Primary Care Physician_____Phone_____.

Which part of your body hurts the most?_____.

How long have you had this pain?_____.

Was pain caused from MVA/Trauma? ☐ Yes ☐ No Illness: ☐ Yes ☐ No

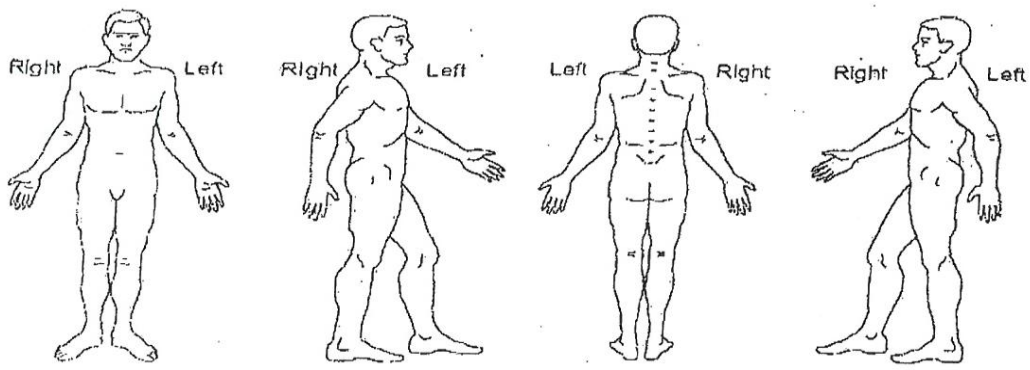
Unknown Cause: ☐ Yes ☐ No

If MVA/Trauma please explain and give dates:_____.

Are you involved in any litigation or lawsuit as a result of your pain? Yes ☐ No ☐

Are you seeking Workers Compensation as a result of your pain? Yes ☐ No ☐

On a scale of 0 to 10, "0" being no pain and "10" being the worst pain imaginable, circle the number that describes your level of pain:



No Pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst Pain Imaginable

Mark the areas on diagram where you have pain and check **ALL** the words that best describe your pain:

☐ Aching ☐ Shooting ☐ Tingling ☐ Radiating ☐ Tightness ☐ Dullness

☐ Stinging ☐ Burning ☐ Stabbing ☐ Numbness ☐ Excruciating ☐ Coldness

☐ Sharpness ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional ☐ Other_____.

Please indicate the factors or activities of daily living that increase or decrease your pain:

Factors	Increase	Decrease	No effect		Factors	Increase	Decrease	No Effect	
Weather					Pressure				
Heat					Sexual Activity				
Cold					Bowel Movement				
Physical activity					Bright Light				
Posture					Sneeze,Cough				
Walking					Sitting				
Lying Down					Sleep				
Appetite					Travel				
Occupation					Communication				

Do you have any of the following?

Neck Pain ☐ Yes ☐ No

Back Pain ☐ Yes ☐ No

Neuropathic/Nerve Pain ☐ Yes ☐ No

Numbness/Tingling ☐ Yes ☐ No

Weakness ☐ Yes ☐ No

Bowel/Bladder Incontinence ☐ Yes ☐ No

Headache: ☐ Yes ☐ No

Pain site:_____ Nature of pain:_____ Duration of pain:_____.

Pain triggers: ☐ Tobacco ☐ Alcohol ☐ Exercise ☐ Noise ☐ Sex ☐ Weather ☐ Menstrual Cycle

☐ Other

Pain symptoms: ☐ Nausea/Vomiting ☐ Photophobia/Phonophobia ☐ Myosis/Ptosis

☐ Lacrimal/Nasal congest

Pain relievers: ☐ Quiet ☐ Dark Room

Please list any physicians you have seen for your pain:

Name Recommendation Specialty

_____. _____. _____.

_____. _____. _____.

_____. _____. _____.

Please check any of the following treatments you have received for this pain problem:

	Details/ Date	Yes	No
☐ Nerve Blocks			
☐ Physical Therapy			
☐ Acupuncture			
☐ Chiropractor			
☐ Psychiatrist/Psychologist			
☐ Surgery			
☐ Other			

Please indicate which diagnostic procedures (tests) you have had for this pain problem:

☐ MRI Scan			
☐ CT Myelogram			
☐ X-Ray			
☐ EMG/NCS			
☐ Bone Scan			
☐ Discogram			

☐ Other			

Please list past or current medical problems:

☐ Heart Disease	☐ Lung Disease	☐ Diabetes	☐ Stroke	☐ Herpes
☐ Hypertension	☐ Kidney Problems	☐ Liver Disease	☐ Seizures	☐ Open Wound
☐ Migraines	☐ Thyroid Disease	☐ Depression/Anxiety	☐ GERD	☐ Current Infection
☐ Other				

Have you ever been diagnosed with Cancer? ☐ Yes ☐ No If yes what type:_____.

Currently receiving treatment? ☐ Yes ☐ No if yes what type:_____.

Please list all medications you are currently taking:

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

Are you taking narcotics from any physician? ☐ Yes ☐ No

Do you have any allergies to medication or food? ☐ Yes ☐ No

Please list your allergies and the reaction below :

Medication	Reaction	Medication	Reaction
1.		4.	
2.		5.	
3.		6.	

Have you ever taken or been given:

Anticoagulants, Blood-thinners, Coumadin ,Plavix, Pletal : ☐ Yes ☐ No Reaction_____.

Cortisone or Steroids ☐ Yes ☐ No Reaction_____.

Please List any Surgeries:

Surgery/Date | Surgery/Date

1.	5.
2.	6.
3.	7.
4.	8.

Review of Systems:

Cardiovascular	Respiratory	Genitourinary	Muscle/Joint Disease
☐ Palpitations	☐ Chronic Cough	☐ Change of Bowel Control	☐ Redness in Joints
☐ Leg/Ankle Swelling	☐ Wheezing	☐ Change of Bladder Control	☐ Arthritis
☐ Chest Pain/Angina	☐ Sputum Production	☐ Blood in Urine	☐ Muscle Spasms
☐ Hypertension	☐ COPD/Asthma	☐ Painful Urination	☐ Back or Neck Issues
☐ Shortness of Breath	☐ Other	☐ Other	☐ Swelling of Joints
☐ Other			☐ Other

Neurological	Endocrine	Gastrointestinal	Hematologic
☐ Epilepsy/Seizures	☐ Frequent Urination	☐ Nausea	☐ Easy Bleeding
☐ Weakness	☐ Change in Appetite	☐ Diarrhea	☐ Poor Blood Clotting
☐ Dizziness/Fainting	☐ Heat/Cold Intolerance	☐ Rectal Bleeding	☐ Bleeding Disorder
☐ Numbness	☐ Sweating	☐ Heart Burn/GERD	☐ Other
☐ Headache	☐ Other	☐ Constipation	
☐ Other		☐ Liver Disease	
		☐ Other	

Psychiatric	Constitutional
☐ Depression	☐ Recent Weight Loss
☐ Anxiety	☐ Recent Weight Gain
☐ Stress	☐ Fever/Chills
☐ Previous Psychiatric Care	☐ Visual Change
☐ Other	☐ Hearing Change
	☐ Sleep Abnormalities
	☐ Other

Have you been tested for HIV Virus? ☐ Yes ☐ No

Date_____ ☐ Positive ☐ Negative

Have you been diagnosed with any of the following?

Hepatitis ☐ Yes ☐ No

Any Sexually transmitted diseases ☐ Yes ☐ No

Social History:

Do you currently work? ☐ Yes ☐ No What is your occupation_____.

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed Number of children:_____.

Education:_____.

Dominate Hand: ☐ Right ☐ Left Is there any possibility that you are pregnant ☐ Yes ☐ No

Do you use any of the following? ☐ Cigarettes ☐ Alcohol ☐ Cocaine ☐ Marijuana ☐ Heroin

☐ Club Drugs ☐ Methamphetamine ☐ Prescription Drugs ☐ Other

If yes, the last time used:_____.

Family History:

	Living	Age	Yes	No	Medical History or Cause of Death
Father					
Mother					
Brother					
Sister					