

VALLEY CENTER FOR
Nerve Studies & Rehabilitation
ERIC R. BECK, MD, PHD, FAAPMR
Experienced, personalized care for effective results
256.382.1603

Today's Date _____

Patient's Legal Name _____

LAST FIRST MIDDLE

Age _____ Date of Birth _____ Male Female Occupation _____

Referred by _____ Family Physician _____

What brings you in today? _____

List all medications that you are currently taking (prescription and non-prescription): See attached medication list

Medication Name	Dosage	Times/Day	Medication Name	Dosage	Times/Day

ARE YOU ALLERGIC TO ANY MEDICATIONS?: Yes No **Latex Allergy?:** Yes No

List any medications that you are allergic to and the reaction it causes:

Prior Surgeries: _____

ROS	Please check all CURRENT positive findings that apply to you or mark none.							
CONSTITUTIONAL	<input type="checkbox"/> weight loss	<input type="checkbox"/> weight gain	<input type="checkbox"/> loss of appetite	<input type="checkbox"/> weakness	<input type="checkbox"/> NONE			
EENT	<input type="checkbox"/> blurry vision	<input type="checkbox"/> hoarseness	<input type="checkbox"/> ringing in ears	<input type="checkbox"/> NONE				
CARDIAC	<input type="checkbox"/> chest pain	<input type="checkbox"/> irregular heartbeat	<input type="checkbox"/> swelling in the legs or feet	<input type="checkbox"/> NONE				
RESPIRATORY	<input type="checkbox"/> pain when breathing	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> NONE					
GASTROINTESTINAL	<input type="checkbox"/> liver problems	<input type="checkbox"/> blood in stool	<input type="checkbox"/> gallbladder problems	<input type="checkbox"/> NONE				
GENITOURINARY	<input type="checkbox"/> bladder problems	<input type="checkbox"/> incontinence	<input type="checkbox"/> pain with urination	<input type="checkbox"/> kidney stones	<input type="checkbox"/> NONE			
INTEGUMENTARY	<input type="checkbox"/> rashes	<input type="checkbox"/> skin ulcers	<input type="checkbox"/> changes in skin	<input type="checkbox"/> NONE				
NEUROLOGICAL	<input type="checkbox"/> headaches	<input type="checkbox"/> numbness/tingling	<input type="checkbox"/> seizures	<input type="checkbox"/> dizziness	<input type="checkbox"/> faintness	<input type="checkbox"/> NONE		
MENTAL HEALTH	<input type="checkbox"/> depression	<input type="checkbox"/> sleep disorder	<input type="checkbox"/> nervousness	<input type="checkbox"/> fainting spells	<input type="checkbox"/> NONE			
HEMATOLOGIC	<input type="checkbox"/> easy bleeding	<input type="checkbox"/> easy bruising	<input type="checkbox"/> bleeding problems	<input type="checkbox"/> NONE				
ENDOCRINE	<input type="checkbox"/> thyroid problems	<input type="checkbox"/> low blood pressure	<input type="checkbox"/> thirst	<input type="checkbox"/> NONE				
MUSCULOSKELETAL	<input type="checkbox"/> joint pain	<input type="checkbox"/> muscle pain	<input type="checkbox"/> cramps	<input type="checkbox"/> limitation in motor activity	<input type="checkbox"/> NONE			

HISTORY	Please check all that apply (Family refers to parents, brothers, sisters, or children)								
Condition	You	Family	Condition	You	Family	Condition	You	Family	
Jaundice or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Type	_____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>				

(Continued on Reverse Side)

Have you ever been diagnosed/treated for any other conditions/illnesses not listed in current positive findings or history?

WOMEN: Are you pregnant? Yes No Date of last menstrual period: _____

SOCIAL HISTORY:

Do you smoke? Yes No # of Years _____ Packs per day _____

Do you drink alcoholic beverages? Yes No _____ Drinks per week _____

Occupation: _____ Currently Working: Yes No

I hereby certify by my signature that the medical information given on this form is correct to the best of my knowledge.

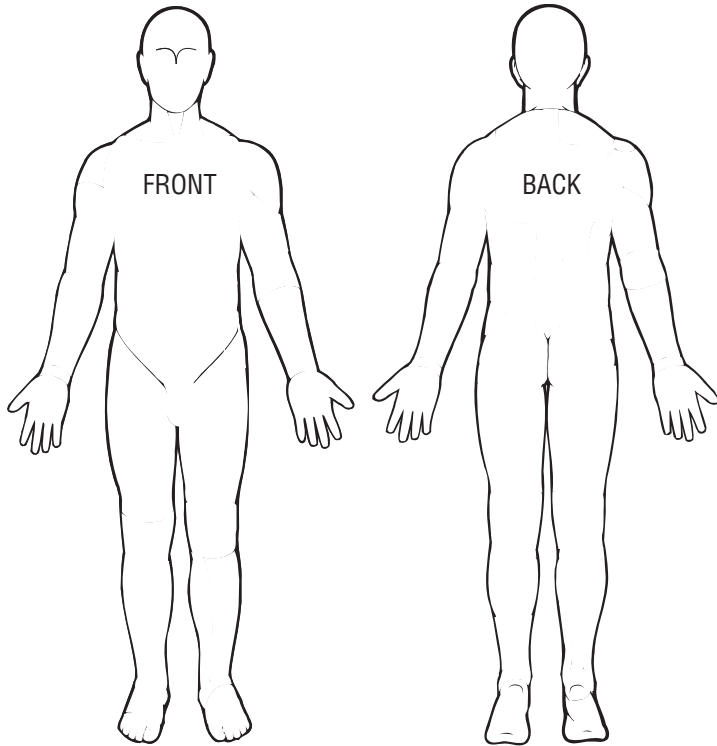
PATIENT SIGNATURE

DATE

FOR OFFICE USE ONLY

PHYSICAL EXAMINATION: Patient Name: _____ DOB _____

Vital Signs: B/P _____ P _____ R _____ T _____ Height _____ Weight _____

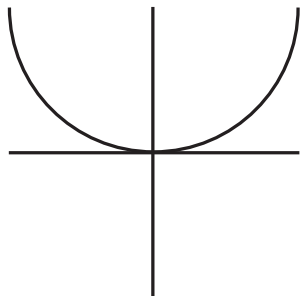


CN _____ X-XII WNL _____ ABNL _____

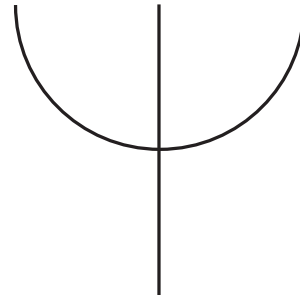
Motor _____ WNL _____ ABNL _____

Sensory _____ WNL _____ ABNL _____

Gait _____ Toe _____ Heel _____ Tandem _____



NECK



BACK