LAKESIDE
SPORTS & PAIN CLINIC

Welcome to the office of Mark Wheaton, M.D. We look forward to meeting you and serving you to the best of our abilities. During your first visit, you can expect to spend approximately 60-75 minutes with the physician and his staff. We will begin by reviewing the history related to your problem and previous tests and treatments. Dr. Wheaton will then examine you and discuss the results of his exam and recommendation for treatment. One of our staff will then go over a detailed estimate of cost of treatment recommendations. Your initial exam will allow for time to be treated, if that is what you and Dr. Wheaton decide.

Prior to your appointment, we request that you fill out the following information and then bring the completed forms with you to your first visit. If any films or tests, including x-rays, MRIs, EMGs or CT scans have been performed within the past 3 years, please arrange to bring these with you, or at the very least a copy of the written reports. You can always ask the facility to send them to us as well (fax # 952-593-4005).

Please be sure to review our Financial Policy before signing it. Our goal is to keep you well-informed of your treatment options and the costs involved.

Items to bring with you to your first visit:

☐ Your completed forms

☐ Photo ID

☐ X-ray / MRI images and/or reports

☐ Cash, Check or credit card to pay at time of service

Should you have any questions, please feel free to contact our office at (952) 593-0500

********Personal Information********

Name_____

DOB ____/____/____ Sex: Male Female

Home Address _____Phone: Home ( ) _____

City, State & Zip _____ Work ( )_____

Email _____ Cell ( )_____

What is your preferred contact method? Phone (please specify) or email

Emergency Contact/relationship to you_____
Phone (____) ____-_____

Do you authorize Lakeside Sports & Pain Clinic to discuss your care with anyone?

Name/Relationship to you
_____

Patient signature _____ Date ___/___/___

*__Female Patients__: Would you prefer to have a female present during your exams / treatment? yes / no

Is this claim related to:

Auto accident? **NO** **If yes, what was the date of injury? __/__/____**

Work injury? **NO** **If yes, what was the date of injury? __/__/____**

REFERRAL -- How did you hear about our office?

_____

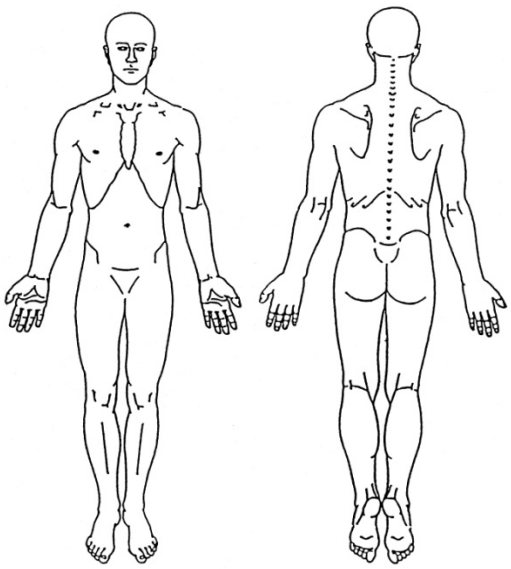
*****Patient History*****

What area(s) of your body are you being seen for? (circle all that apply)

Neck	Shoulder	Elbow	Wrist	Hand	TMJ
Upper Back	R L	R L	R L	R L	R L
Low Back	Hip	Knee	Ankle	Foot	Pelvis

Other_____

Place an "x" on the diagram below in the location(s) where you experience pain or other symptoms



Date of Injury __/__/____

Briefly describe the injury and onset of symptoms.

_____

_____

_____

Have you injured <u>this area</u> previously? If yes, when and how?

_____

_____

Circle any words that describe your pain or symptoms:

Sharp	Tingling	Burning	Sore	Dizziness	Headaches	Dull
Numbness	Cramping	Weak	Nausea	Arm/hand symptoms		Shooting
Aching	Tight	Fatigued	Ear ringing	Leg/foot symptoms		

Other_____

What is your average daily pain rating (1 is the least and 10 is the worst) 1 -_____- 10

Circle how often and/or when do you experience pain:

Morning Evening Night Constant

With movement/activity Sitting Standing Walking

What activities INCREASE or cause your pain/symptoms?

_____

What activities DECREASE or relieve your pain/symptoms?

_____

What activities/exercises are limited?

_____

How active are you? Sedentary Moderate exercise Vigorous exercise

What type(s) of exercise do you participate in regularly?

_____

How often do you exercise?

Never Occasionally 2-3 times/week 3-4 times/week daily

How will you define treatment success?

Freedom from **all** pain Yes No Tolerating simple activities Yes No

Any amount of pain relief Yes No Doing all desired activities Yes No

Medications ***(Please list)***

Note: If you are unsure of what you are taking, please bring all medications & Supplements with you.

Current PAIN medications (include dosages)	Past Pain Medications (include dosages)	Other Medications (include dosages)	Vitamins/Supplements (include ingredients & dosages)

Do you have any known allergies to any medications / substances?

None _____

What, if any, type of treatment are you CURRENTLY receiving?

None _____

Please let us know about PAST treatments for this condition:

Treatment	*Approximate Date(s)*	*Response to treatment*
Physical Therapy		
Chiropractic Care		
Massage		
Acupuncture		
Cortisone Injections		
Other		

*****Medical / Family / Social History*****

Circle any history of the following condition in your health or your immediate family's health & state who has the condition.
Heart Disease Who? _____Cancer: What kind? _____ Who? _____
Stroke Who? _____High Blood Pressure: Under control? Y N Who?_____
Diabetes: Under control? Y N Who?_____Other_____

List any pertinent surgeries you have had and date(s).

1._____ __/__/__ 2. _____ __/__/____
3. _____ __/__/__4. _____ __/__/____

Marital Status? Single Married Widowed Divorced Separated
Do you have children? Yes No **Number of Sons_____ Number of Daughters_____**
Do you have a religious affiliation? Yes No N/A **What religion? _____**
Does this religion play an important part in your life? Yes No N/A

*****Employment*****

Are you working? Full or Part-time Unemployed Off-work due to injury Student Retired
What is your occupation?

_____

Who is your employer?

_____

Do you have any current work restrictions due to your injury? Yes No
If so, please list here:

_____

********Additional Information********

Circle any other types of symptoms you have been experiencing:

Constitutional:
chills
fatigue fever
weight gain
weight loss
weakness
night sweats

Genitourinary:
blood in urine
frequent urination
urge incontinence
urinary incontinence

Endocrine:
diabetes
change in appetite
heat / cold intolerance
excessive hunger/thirst

ENMT:
dry mouth
ear pain / pressure
nasal congestion
sinus pain / pressure
ringing in ears

Musculoskeletal:
muscle weakness
joint stiffness
leg cramping

Allergic / Immuno:
environmental allergies
food allergies
seasonal allergies

Cardiovascular:
chest pain
irregular heart beat
leg swelling
fainting

Skin:
itchy skin
rash
bruising
hair loss

Neurological:
dizziness
double vision
headache
tingling
numbness

Respiratory:
shortness of breath
wheezing
cough
blood with cough
asthma

Gastrointestinal:
abdominal pain
constipation
diarrhea
rectal pain
heartburn
loss of appetite

Psychiatric:
anxious
depressed
insomnia or other sleep trouble
memory loss

Please comment on any other health issue(s) that should be brought to our attention:

_____

Do you use tobacco? Yes No **What type?** Cigarettes Chew Pipe Other___

How much? _____ Number of years_____ Year quit_____

Do you drink alcohol? Yes No **What type?** Beer Wine Liquor

How much at a given time? _____ How often?_____ Year quit?_____

Do you use caffeine? Yes No **What type?** Chocolate Coffee Soda Tea Tablets

How much at a given time?_____ How often?_____ Year quit?_____