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

Personal Information

Name_____

DOB ____/____/____ Sex: ☐ Male ☐ Female

Home Address _____ Phone: Home ( ) _____

City, State & Zip _____ Work ( ) _____

Email _____ Cell ( ) _____

What is your preferred contact method? ☐ Phone ☐ 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

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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? __/__/____

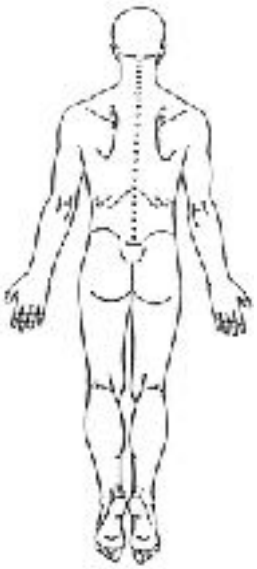
REFERRAL -- How did you hear about our office?_____

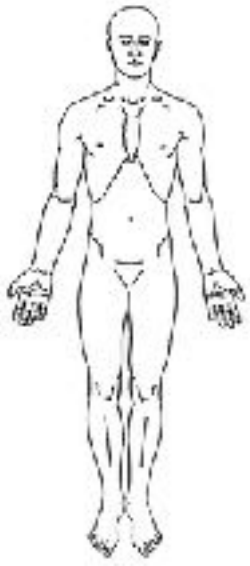
Patient History

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

- ☐ Neck
- ☐ Upper Back
- ☐ Lower Back
- ☐ Sacroiliac
- ☐ Shoulder ☐R ☐L ☐Both
- ☐ Elbow ☐R ☐L ☐Both
- ☐ Wrist ☐R ☐L ☐Both
- ☐ Hand ☐R ☐L ☐Both
- ☐ Hip ☐R ☐L ☐Both
- ☐ Knee ☐R ☐L ☐Both
- ☐ Ankle ☐R ☐L ☐Both
- ☐ Foot ☐R ☐L ☐Both

Place an "x" on the diagram below in the location(s) where you experience pain or other symptoms and RATE your symptoms 0-10 for pain (10 is excruciating).





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Briefly describe the injury and onset of symptoms.

_____

_____

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

_____

_____

Check any words that describe your pain or symptoms:

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

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

- ☐ Morning
- ☐ Evening
- ☐ Night
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Constant
- ☐ With movement/activity

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
- ☐ as needed

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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):

1. _____ 3. _____
2. _____ 4. _____

Past Pain Medications (include dosages):

1. _____ 3. _____
2. _____ 4. _____

Other Medications (include dosages):

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

Vitamins/Supplements (include ingredients & dosages):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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

☐ **None** **Yes** _____

☐ **Adhesive Tape** ☐ **Iodine** ☐ **Latex**

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

☐ **None** **Yes** _____

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Please let us know about PAST treatments for this condition:

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Chiropractic Care
- ☐ Cortisone Shot
- ☐ Acupuncture
- ☐ Massage
- ☐ Electrotherapy
- ☐ _____
- ☐ _____

Medical/Family/Social History

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

1. _____
2. _____
3. _____
4. _____

Marital Status? ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Employment

Are you working?

- ☐ Full-time
- ☐ Part-time
- ☐ Retired
- ☐ Unemployed
- ☐ Off-work due to injury
- ☐ Student

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

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___

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

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

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Circle any other types of symptoms you have been experiencing:

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

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

Cardiovascular:
- chest pain
- fainting
- irregular heart beat
- leg swelling

Skin:
- bruising
- itchy skin
- hair loss
- rash

Neurological:
- dizziness
- double vision
- headache
- numbness
- tingling

Respiratory:
- asthma
- blood with cough
- cough
- shortness of breath
- wheezing

Allergic / Immuno:
- environmental allergies
- food allergies
- seasonal allergies

Genitourinary:
- blood in urine
- frequent urination
- urge incontinence
- urinary incontinence

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

Musculoskeletal:
- arthritis
- joint stiffness
- leg cramping
- muscle weakness

Psychiatric:
- anxious
- depressed
- insomnia or other sleep trouble
- memory loss

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