O Dr. Donald Antonelli/ODr. Frank Halter
2575 Morris Avenue Union, NJ 07083
908-688-7373 Fax# 908-688-8049

General Information

Name: Date: _____

Social Security Number: _____ Primary care physician Name:

Patient Sex: M___ P Date of Birth: _____ Age:

Patient Address:
Street Town Zip Code

Home Phone: _____ Work Phone: _____

Cellular Phone: _____ Marital Status: M S D W

Patient Employer/School: Occupation: _____

Subscriber Name(If different from patient): _____ SSN:_

Subscriber Employer(If different from patient): _____

Referred for Treatment by: _____

E-Mail address: _____

Complaint History:

1. Describe your current complaint and how it began: _____
   How long have you had this condition: _____ Date of onset: ,

2. How would you describe this pain?
   ❑ Sharp ❑ Soreness ❑ Throbbing ❑ Tingling ❑ Dull ❑ Stiffness
   ❑ Spasm ❑ Burning ❑ Weakness ❑ Ache ❑ Numbness ❑ Shooting

5. How would you rate the intensity of your pain?

0 | 2 3 4 5 6 7 8 9 10
(no pain) Moderate pain Unbearable pain

6. How often is the pain present?
   ❑ Constant (8 1 - 100%) ❑ Frequent (51-80%) ❑ Occasional (26-50%) ❑ Intermittent (25% or less)

8. Since your pain began is it getting?
   ❑ Better ❑ Worse ❑ Staying the same ❑ Moving/changing location

9. How did your problem begin?
   ❑ Auto accident ❑ Work related accident ❑ Other type of accident
   ❑ Gradual ❑ Sudden ❑ No specific reason

10. What makes your problem better?
    ❑ Nothing ❑ Walking Standing ❑ Silting ❑ Moving around/exercise ❑ Lying down ❑ Inactivity

8. What makes your problem worse?
   ❑ Nothing ❑ Walking Standing ❑ Sitting ❑ Moving around/exercise ❑ Lying down ❑ Inactivity

9. Are you currently taking any medication? ❑ Yes ❑ No
   If yes, Please list _____

10. Were you previously treated for an earlier occurrence of this same condition?
    If yes, please list the type of Doctor and his/her name _ _.__~ _____

11. What is your physical activity at work?
    ❑ Mostly sitting ❑ Light manual labor ❑ Moderate manual labor ❑ Heavy manual labor

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Patient Health Assessment (cont.)

12. Do you exercise?
☐ No regular exercise ☐ 1-2 times a week ☐ 3-4 times a week ☐ 5-7 times a week
☐ Cardiovascular ☐ Stretching ☐ Weight Machine ☐ Free Weights ☐ Sports _____ Type

13. What is your present general stress level:
☐ No stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

14. Is your problem affecting your ability to work or do other routine daily activities?
☐ No effect ☐ Have some limited physical restrictions, but can function
☐ Need some assistance with daily activities ☐ Cannot work
☐ Cannot function without assistance ☐ Totally disabled

Past Or Present Symptoms, Conditions Or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck pain	☐	☐	High blood pressure	☐	☐
Shoulder pain	☐	☐	Heart condition	☐	☐
Arm/elbow pain	☐	☐	Respiratory condition	☐	☐
Hand pain	☐	☐	Digestive problems	☐	☐
Upper back pain	☐	☐	Kidney/bladder problem	☐	☐
Lower back pain	☐	☐	Menstrual problems	☐	☐
Pain in upper leg or hip	☐	☐	Breast soreness/lump	☐	☐
Pain in lower leg or knee	☐	☐	Sinus conditions	☐	☐
Pain in ankle or foot	☐	☐	Allergies/asthma	☐	☐
Jaw pain	☐	☐	Cancer	☐	☐
Swelling/stiffness of joints	☐	☐	Stroke	☐	☐
Headaches	☐	☐	Excessive weight loss/gain	☐	☐
Dizziness	☐	☐	Skin condition	☐	☐
Fainting spells	☐	☐	Arthritis	☐	☐
Convulsions	☐	☐	Diabetes	☐	☐
General prolonged fatigue	☐	☐	Prostate condition	☐	☐
Condition of uterus/ovaries	☐	☐			

Tobacco use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Alcohol use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Caffeine use: *(Coffee, tea, soft drinks)*
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Pregnancy: ☐ Past ☐ Present

Surgical Procedure:
☐ Past ☐ Present

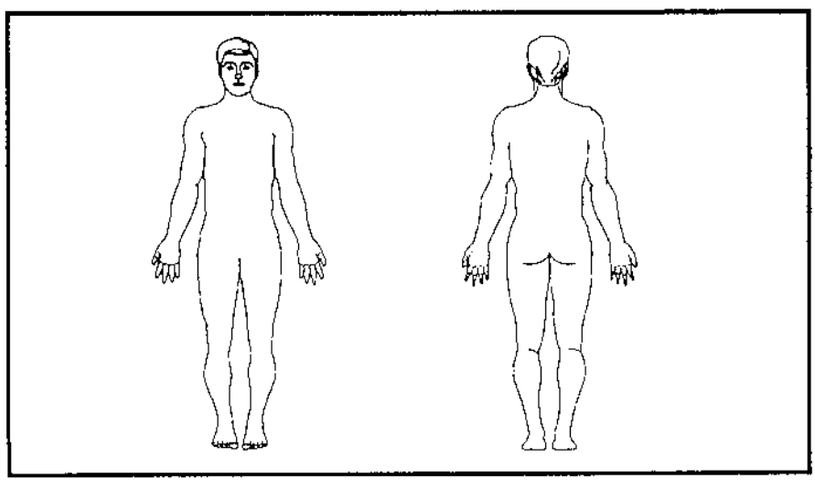
Please list: _____

_____

Comments: _____

_____

Please shade in the figures below where you have pain, or other symptoms:



I have reviewed the information contained on this form with the patient.

_____
Patient Name

_____
Provider Initials

_____
Date