



Samuel Gray DC

Leonard Weinberger MSN-FNP

All no call/no show appointments without a 24 notice to reschedule or cancel will be subject to a \$75 Cancellation Fee.

Initial Evaluation

Demographics

Patient Name: _____ DOB: _____ Today's Date: _____

Referred By: _____ PCP: _____

Medical History

Chief Complaint(s):

History of Present Illness:

Quality of Pain: Burning Sharp Throbbing Aching
 Spasms Numbness Stabbing Pins and Needles
Other: _____

Timing: Constant Intermittent

PATIENTS: PLEASE FILL OUT THE FIRST AND SECOND PAGE ONLY!



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Aggravating Factors: Coughing Sneezing Walking Standing Sitting
Bending (forward/backward)
Prolonged sitting, standing or walking

Alleviating Factors: Sitting Standing Lying Down Walking
Medication Ice Heat

Social History

Smoker? Yes No

Alcohol?: Yes No

Frequency: Rarely Occasionally Frequently

Substance Yes No

Abuse?

THC?: Yes No

CBD?: Yes No

Assistive Devices

Do you use any of the following for your pain?

Braces Tens Unit Cane Walker Wheelchair

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THE FOLLOWING QUESTIONS ARE FOR NURSE PRACTITIONER USE ONLY!

Patient Name: _____ DOB: _____ Today's Date: _____

VAS: _____/10

Gait: Normal / Cane / Walker / Wheelchair / Limping / Other: _____

Review Of Systems

General: ___ WD ___ WN ___ Overweight ___ Obese

Other: _____

Extremities: ___ Edema ___ Cyanosis ___ Deformity

Neuro: ___ CN II-XII ___ Motor Weakness ___ Sensory Changes

Concentration: ___ Good ___ Poor

Coping with Pain: ___ Yes ___ No ___ Difficulty

Deconditioning: ___ Yes ___ No

Motivated to work with pain management: ___ Yes ___ No

Local Examination:

Previous Treatments:

___ Chiropractor: _____ ___ Acupuncture: _____

___ Previous Injection Therapy: _____ Dates: _____

___ Pain Physician: _____ ___ NSAIDs/Opioids: _____

___ Past Surgery for Pain: _____

Physical Therapy:

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Dates of Last Treatment: _____ Improved / No Relief / Worsened

Duration: _____ Weeks: _____ x Per Week: _____ Outcome: Completed/Discharged:

MRI/CT Scans/X-Rays: _____

Weight Management:

Maintaining Healthy Weight? ☐ Yes ☐ No

If answered no to the previous question, was weight loss discussed? ☐ Yes ☐ No

Recommended: Increased Exercise ☐ Yes or ☐ No

Proper Nutrition and Diet: _____

Impression / Diagnosis:

Assessment/Plan:

☐ The patient was seen, examined, intake forms were reviewed

☐ Treatment options were discussed

- A.) PRP/Exosome
- B.) TPI
- C.) Cortisone Injection
- D.) IV Therapies
- E.) Peptide Therapy

Final Treatment Plan:

Education/Counseling:

☐ Chronic Narcotic Use ☐ NSAIDs ☐ PRP ☐ TPI ☐ Cortisone
☐ Peptide Therapy ☐ IV Therapy ☐ Drug Interactions

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☐ Weight Loss ☐ Pre/post procedure instructions

☐ Oswestry Pain Disability Questionnaire

Complexity of medical decision making:

☐ Straight Forward ☐ Low Complexity ☐ Moderate Complexity ☐ High Complexity

Duration of Visit: _____ Duration of Counseling Patient: _____

I evaluated, assessed and counseled this patient. Treatment plan was discussed and all questions were answered.

Provider Signature: _____

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