Michael J. Simek, MD
501 W. Schrock Road, Ste. 103, Westerville, OH 43081
3823 Trueman Court, Hilliard, OH 43026
Phone: 1-614-794-5069 | Fax: 1-614-797-4505
www.ahni.com

NEW PATIENT INFORMATION

Date: _____

Name: _____

Date of birth: _____ Age: _____

Referring doctor or therapist: _____

☐ Other (how did you hear about Dr. Simek?) _____

Are you: ☐ Right-handed ☐ Left-handed ☐ Both (ambidextrous)

REASON FOR VISIT

Location of your pain: ☐ Head ☐ Shoulder ☐ Mid back ☐ Leg ☐ Ankle/foot ☐ Wrist/hand

☐ Neck ☐ Headaches ☐ Low back ☐ Knee ☐ Hips/buttocks ☐ Arm

HISTORY OF PRESENT ILLNESS

Date of injury or when symptoms began: _____

Type of injury:

☐ Sports injury ☐ Job accident ☐ Car accident (Were you the ☐ driver or ☐ passenger? Seat belt on? ☐ No ☐ Yes)

☐ Other (explain): _____

Describe how you injured yourself: _____

_____

_____

Describe your current symptoms: _____

_____

_____

Circle the number that best describes the severity of your pain.

"0" means no pain and "10" is the worst pain you can imagine.

At its worst:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10

Which of the following best describes the type of pain you have:

☐ Constant ☐ Throbbing ☐ Burning ☐ Not deep

☐ On and off ☐ Aching ☐ Tingling/numbness ☐ Deep

☐ Brief ☐ Sharp ☐ Dull

What makes your pain worse? _____

What makes your pain better? _____

How long/far can you: Sit _____ Stand _____ Walk _____

Since your injury happened, is your pain: ☐ Better ☐ Same ☐ Worse

If your pain has changed, what percentage? 10 20 30 40 50 60 70 80 90 100%

Have you had any loss of bowel or bladder control? ☐ No ☐ Yes

PREVIOUS TREATMENT

Have you had treatment since your injury? ☐ No ☐ Yes Have you been to the ER for this? ☐ No ☐ Yes

Have you had any of the following tests or procedures?

X-rays ☐ No ☐ Yes MRI ☐ No ☐ Yes Spinal injections ☐ No ☐ Yes

CT scan ☐ No ☐ Yes EMG ☐ No ☐ Yes

Other tests (please explain) _____

Medical:

Dr._____ Date of first visit_____ Last visit _____

Diagnosis given _____

Medications given _____

Treatment provided _____

Chiropractic: ☐ No ☐ Yes

Dr._____ Date of first visit_____ Last visit _____

Diagnosis given _____

Has it helped? ☐ No ☐ Yes

Physical therapy: ☐ No ☐ Yes

Therapist_____ Date of first visit_____ Last visit _____

Has it helped? ☐ No ☐ Yes Home exercise plan given? ☐ No ☐ Yes

CURRENT MEDICATIONS

Name	Dose	How many times each day?

MEDICATION ALLERGIES: No ☐ Yes ☐

If yes, please list:

Name	Reaction

Are you allergic to or have you ever reacted to iodine, shellfish, IVP dye or contrast media? No ☐ Yes ☐

REVIEW OF SYSTEMS

Please check any symptoms that you have now:

General
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weakness
- ☐ Weight gain
- ☐ Weight loss

Head/hearing/vision
- ☐ Blurred vision
- ☐ Double vision
- ☐ Facial pain
- ☐ Headache
- ☐ Ringing in ears
- ☐ Vertigo/dizziness
- ☐ Vision loss

Lungs/respiratory
- ☐ Asthma
- ☐ Cough
- ☐ Dyspnea/shortness of breath
- ☐ Recent infections
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Leg swelling
- ☐ Syncope/fainting
- ☐ Irregular heartbeat/ palpitations

Digestive
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Black tarry stools
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Genitourinary
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Loss of bladder control

Metabolic/endocrine
- ☐ Cold intolerant
- ☐ Heat intolerant
- ☐ Hair loss

Nervous system
- ☐ Difficulty walking
- ☐ Poor coordination
- ☐ Memory loss
- ☐ Muscle weakness
- ☐ Paresthesia/numbness/tingling
- ☐ Seizures
- ☐ Tremors

Psychological
- ☐ Anxiety
- ☐ Depression
- ☐ Unable to sleep

Skin
- ☐ Itchy skin
- ☐ Rash
- ☐ Skin infections
- ☐ Skin lesions

Blood
- ☐ Bleeding
- ☐ Bruising

FAMILY HISTORY

Please check any condition that a blood relative has a history of:

- ☐ Alcoholism
- ☐ Arthritis
- ☐ Cancer
- ☐ type:_____
- ☐ Cardiovascular disease
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Drug abuse
- ☐ High cholesterol
- ☐ Hypertension/high blood pressure
- ☐ Liver disease
- ☐ Mental illness
- ☐ Muscle disease
- ☐ Parkinson's disease
- ☐ Narrowed arteries
- ☐ Stroke
- ☐ Thyroid disease

PAST MEDICAL HISTORY

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
  type:_____
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Drug abuse
- ☐ High cholesterol
- ☐ Fibromyalgia
- ☐ Overweight/obese
- ☐ Hypertension/high blood pressure
- ☐ Heart attack
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Peptic ulcer disease
- ☐ Renal/kidney disease
- ☐ Seizure disorder
- ☐ Stroke
- ☐ Thyroid disease

_____

PAST SURGICAL HISTORY

Please list type of surgery and approximate date:

- ☐ Spine fusion (neck/upper back/lower back)
- ☐ Vertebra removal (neck/upper back/lower back)
- ☐ Disc removal (neck/upper back/lower back)
- ☐ Hip replacement (R/L)
- ☐ Carpal tunnel release
- ☐ Gastric bypass
- ☐ Knee replacement (R/L)
- ☐ Rotator cuff repair (R/L)
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

SOCIAL HISTORY

Marital status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Living with someone
- ☐ Separated

Number of children

_____

Are you currently employed?
☐ No ☐ Yes

If yes, what type of job?

_____

Do you smoke?
☐ No ☐ Yes

Caffeine use?
☐ No ☐ Yes

Previous smoker?
☐ No ☐ Yes

Do you drink alcohol?
☐ No ☐ Yes

Do you use recreational drugs?
☐ No ☐ Yes

What type/how often?

_____

Mark the drawings with the symbols below to show where you're having pain or discomfort. Include areas of radiating pain or numbness as well.

Numbness	Tingling	Burning	Stabbing/sharp	Aching	Cramping
o o o	: : ::	X X X	////	^ ^ ^	□ □ □