Independent Medical Evaluation Consent

Dr. Ludwig will be providing a medical opinion to the requesting party, and he will not be your treating physician.

You should not perform any activities during the course of evaluation which you feel are in excess of your abilities or which cause you significant discomfort.

Dr. Ludwig will not be sharing his opinions or recommendations with you after the evaluation. His report may be available by requesting a copy from the requesting party.

If you choose to record audio of the examination, please inform Dr. Ludwig so he can also record audio for his own files. Video recording requires consent of both parties prior to the evaluation.

Do you intend to record audio with this evaluation? (circle one) YES NO

_____ _____

Name Date

New Patient History

Name _____ Age _____

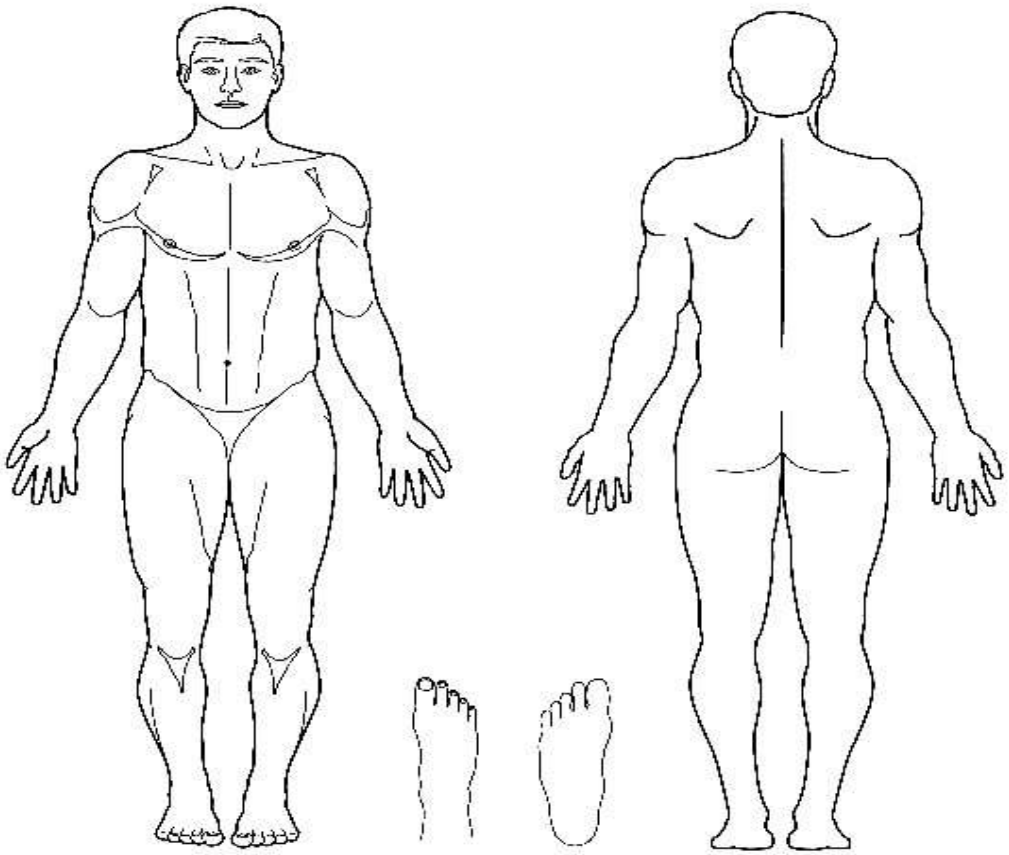
How did you find us? □ Chiropractor □ Therapist □ Friend/relative □ Internet
□ Doctor referral _____ □ Other _____

1. My current pain developed: □ Gradually □ Suddenly Date of onset ___/___/_____
□ Motor vehicle accident Attorney: _____
□ Work injury: Date of injury _____/____/_____

2. Please make a mark on the line below to show your average pain level over the past week.

No Pain ——————————— Worst pain Imaginable

Please use the following key to shade in the distribution of your pain on the figures:
Numbness …….. **Pins and Needles** 00000000 **Pain** ///////////////



3. My pain is best described as (check all that apply):

□ Constant	□ Intermittent			
□ Dull	□ Sharp	□ Throbbing	□ Burning	□ Tingling
□ Aching	□ Stabbing	□ Shooting	□ Electrical	

4. My pain is worse with (check all that apply): □ Bending forward □ Bending backward

□ Sitting	□ Standing	□ Walking	□ Laying down
□ Looking up	□ Looking down	□ Turning left	□ Turning right
□ Cough/ sneeze	□ Lifting	□ Pushing / pulling	

5. My pain is better with: □ Laying down □ Sitting □ Standing □ Therapy
□ Changing positions □ Pain meds □ Ice □ Heat □ Nothing

6. Have you experienced **new** bowel or bladder leakage/accidents recently? □ Yes □ No

7. Have you had any of the following tests for the current problem in the last 2 years?
□ X-rays □ CT scan □ MRI □ EMG □ Bone scan
□ Diagnostic Spinal Injections (e.g. epidural, facet/sacroiliac joint block, discogram)

8. Have you tried the following treatments for my pain (Circle those that helped):
□ Physical Therapy □ Chiropractic □ Acupuncture □ Massage
□ Spinal Injections □ Home/gym exercises □ Surgery □ Traction

9. Have tried the following medications for my pain (Circle those that helped, X out those that didn't):
□ Anti-inflammatories (Ibuprofen, Aleve, Naproxen, Mobic, Celebrex, Diclofenac, Steroids)
□ Muscle relaxants (Soma, Flexeril, Carbamazepime, Zanaflex, Skelaxin, Robaxin, Methocarbamol)
□ Anti seizure drugs (Neurontin, Gabapentin, Lyrica)
□ Anti-depressants (Paxil, Zoloft, Nortriptyline, Amitriptyline)
□ Narcotics (Lortab, Hydrocodone, Oxycodone, Oxycontin, Ultram, Vicodin, Percocet, Methadone)

10. Medication Allergies: □ None □ Iodine □ Contrast dye □ Steroids □ Local Anesthetics
□ Latex □ Other: _____
Allergic Reaction that occurred**:** _____

11. Are you currently taking any blood thinning/anticoagulation medications? □ YES □ NO
(Coumadin, Warfarin, Pradaxa, Plavix, Aggrenox, Aspirin, Flax seed, Fish Oil etc.)

12. Medications
_____ _____ _____ _____
_____ _____ _____ _____

13. Medical History:
Please check the following medical problems you have now, or have had:

□ Heart problems	□ Thyroid problems	□ Easy bleeding	□ Osteoarthritis
□ Asthma	□ Epilepsy	□ Colon disease	□ Ulcers
□ Diabetes	□ Migraines	□ Vascular problems	□ Kidney problems
□ Stroke	□ Depression	□ Hepatitis/HIV	□ Bladder problem
□ Anxiety	□ Osteoporosis	□ Fibromyalgia	□ Lung Disease
□ Anemia	□ High blood pressure	□ Rheumatoid arthritis	□ Cancer

□ Other:_____
Have you had previous back or neck problems? □*Yes* □*No*
Have your received care from a mental health professional? □*Yes* □*No* □*Still seeing*_____
Have you ever had an infection with MRSA? □*Yes* □*No*

14. Surgical History:
Spine surgery? □ None □ Neck/Cervical □ Mid-back/ Thoracic Spine □ Low back/lumbar
Orthopedic surgery? □ None □ Shoulder □ Elbow □ Wrist □ Hand □ Hip □ Knee □ Ankle □ Foot
Heart surgery or lung surgery? □ No □ Yes
Cardiac or peripheral stents? □ No □ Yes

15. Family History: Please check those illnesses that your family members have had

	Hypertension	Diabetes	Neurologic Problems	Heart Disease	Cancer	Arthritis
Father	□	□	□	□	□	□
Mother	□	□	□	□	□	□
Siblings	□	□	□	□	□	□
Grandparents	□	□	□	□	□	□

Father: □*Living* □*Deceased (Age)* ____ Mother □ *Living* □*Deceased (Age)* ____

16. Social History:

Do you now, or did you ever smoke? □ No □ Yes Packs per day?_____ Quit?_____

Do you drink alcohol?_____ □ No □ Yes □ daily □ rarely

Do you now, or have you ever had a drug or alcohol problem? □ No □ Yes

Please explain:_____

Marital Status: □ Single □ Married □ Divorced □ Widowed

17. Vocational History:

□ Employed Full Time □ Employed Part time □ Retired

□ Regular Duty □ Light Duty □ Disability (reason)_____

Employer:_____

Job Description:_____

Years at current job: _____ Date last worked:_____

Rate your current job satisfaction: □ Very Satisfied □ Satisfied □ Indifferent □ Dissatisfied

Have you ever been on disability? □ No □ Yes: _____

How physically demanding is your job? Check one.

□*Very heavy (lifting > 100 pounds)* □*Heavy (lifting > 60 pounds)* □*Moderate (lifting > 30 pounds)*

□*Light (lifting > 10 pounds)* □*White collar (no lifting)*

18. Review of Systems:

Please check any of the symptoms you have had during the past year.

□*Fever*	□*Chills*	□*Unintentional weight loss of >10 #*	
□*Rashes*	□*Skin infections*	□*Itching of skin*	
□*Cataracts*	□*Glaucoma*	□*Double vision*	□*Loss of vision*
□*Ear infections*	□*Mouth sores*	□*Sore throat*	□*Nasal congestion*
□*Chest pain*	□*Leg swelling*	□*Irregular heart beat*	
□*Short of breath*	□*Cough*	□*Wheezing*	
□*Nausea*	□*Vomiting*	□*Abdominal pain*	
□*Blood in urine*	□*Painful urination*	□*Difficulty urinating*	
□*Dizziness*	□*Seizures*	□*Ringing in ears*	□*Memory loss*
□*Face numbness*	□*Arm numbness*	□*Leg numbness*	□*Sudden weakness*
□*Joint pain*	□*Muscle pain*	□*Difficulty walking*	
□*Depression*	□*Anxiety*	□*Hallucinations*	
□*High blood sugar*	□*Thyroid disorder*	□*Anemia*	

The information I have provided in this document is true and accurate to the best of my knowledge.

_____ _____

Patient Signature Date