Dr Sonya M Clark

1650 Skylyn Drive Suite 380
Spartanburg, SC 29307

NAME:_____ **AGE:** _____
OCCUPATION_____ **DOMINANT SIDE: RIGHT LEFT**

WHAT ARE YOU BEING EVALUATED FOR:_____
HAVE YOU PREVIOUSLY HAD SURGERY ON THE AFFECTED AREA? YES OR NO
IF YES, EXPLAIN?_____
WHERE IS YOUR PAIN? (DIAGRAM ON LAST PAGE)
RATE YOUR PAIN: (0=NO PAIN, 10=WORST PAIN IN YOUR LIFE) 1 2 3 4 5 6 7 8 9 10
WHEN DID YOUR PAIN START? __/__/__ **WAS THERE AN INJURY? YES OR NO**
DID YOUR PAIN/SYMPTOMS OCCUR AFTER AN ACCIDENT? YES OR NO
CAR ACCIDENT WORK ACCIDENT SLIP/FALL (CIRCLE ALL THAT APPLY)
ARE YOU INVOLVED IN A LAW SUIT IN REGARDS TO THIS INJURY? YES OR NO
LAWYER:_____
ARE YOU FILLING A DISABILITY CLAIM, IN REGARDS TO THIS INJURY? YES OR NO
HOW WOULD YOU DESCRIBE YOUR PAIN: (CIRCLE ALL THAT APPLY)
SHARP, STABBING, ACHING, THROBBING, BURNING
DOES ANYTHING RELIEVE YOUR SYMPTOMS. (CIRCLE ALL THAT APPLY)
REST, BRACE, NOSIDS (IBUPROFEN, ALEVE, CELEBREX), INJECTIONS
HAVE YOU HAD ANY TESTS FOR THIS PROBLEM. (CIRCLE ALL THAT APPLY)
X-RAY, NERVE CONDUCTION STUDIES (NCS) EMG, MRI
WHERE DID YOU HAVE THE TESTS?_____ WHEN?_____

ONLY FILL OUT SECTIONS THAT APPLY TO YOUR SYMPTOMS

HAND:
DO YOUR FINGERS GO NUMB OR TINGLE: YES OR NO
WHICH FINGERS?. THUMB INDEX MIDDLE RING SMALL
DO YOU WAKE UP WITH NUMNBNESS OR PAIN? YES OR NO
HAVE YOU WORN A BRACE FOR THIS PROBLEM? YES OR NO DID IT HELP? YES OR NO
HAVE YOU HAD A STEROID INJECTION FOR THIS PROBLEM? YES OR NO
WHEN? HOW MANY TOTAL?
DO YOUR FINGERS HURT? YES OR NO
WHICH FINGERS?. THUMB INDEX MIDDLE RING SMALL
WHICH JOINT HURTS? CIRCLE ON DIAGRAM
WHICH ACTIVITIES BOTHER YOU? (CIRCLE ALL THAT APPLY)
WRITING, OPENING A JAR, PINCHING, OPENING DOORS, TURNING KEYS

WRIST:
DOES YOUR WRIST HURT? YES OR NO WHERE IS YOUR WRIST PAIN? CIRCLE ON DIAGRAM
HAVE YOU WORN A BRACE FOR YOUR WRIST PAIN? YES OR NO
DID THE BRACE HELP WITH PAIN? YES OR NO
DO YOUR FINGERS GO NUMB? YES OR NO

ELBOW:
DOES YOUR ELBOW HURT? YES OR NO WHERE IS YOUR PAIN? CIRCLE ON DIAGRAM
DOES YOUR PAIN RADIATE? YES OR NO WHERE DOES IT RADIATE? (CIRCLE ALL) SHOULDER HAND
HAVE YOU HAD INJECTION INTO YOUR ELBOW? YES OR NO DID THE INJECTION HELP? YES OR NO
CAN YOU STRAIGHTEN AND BEND YOUY ELBOW WITHOUT DIFFICULTY? YES OR NO

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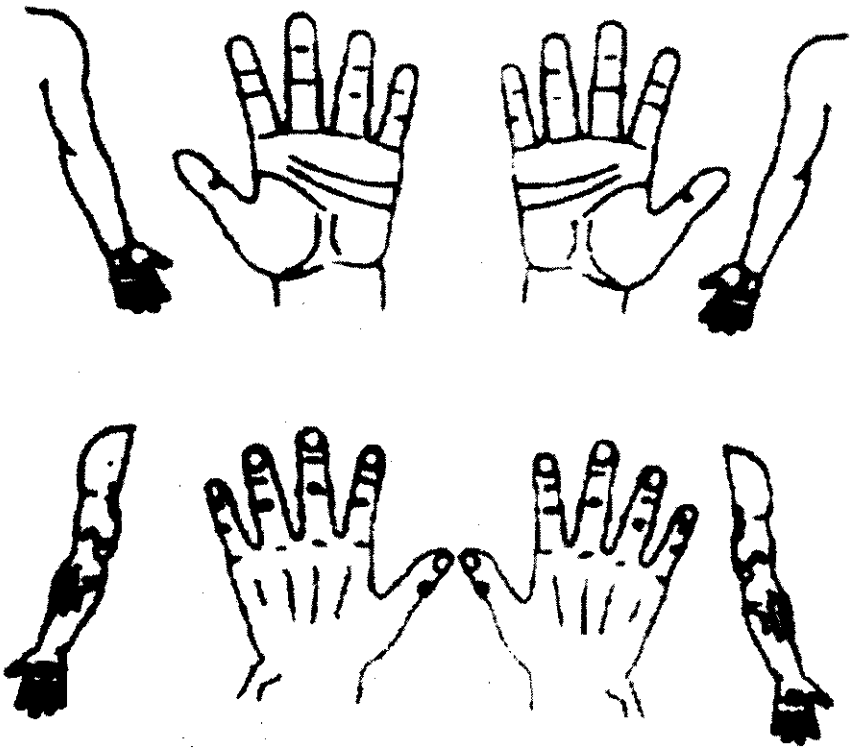
SHOULDER:

DO YOUR SHOULDERS HURT? YES OR NO
DOES IT HURT TO MOVE YOUR SHOULDER? YES OR NO
CAN YOU RAISE YOUR ARM ABOVE YOUR HEAD? YES OR NO
DOES YOUR SHOULDER PAIN WAKE YOU UP AT NIGHT? YES OR NO
DOES YOU HAVE NUMBNESS IN THIS ARM? YES OR NO
DOE YOUR NECK HURT? YES OR NO
DOES YOUR SHOULDER PAIN RADIATE? YES OR NO
WHERE DOES IT RADIATE? NECK ELBOW HAND
HAVE YOU HAD A STEROID INJECTIONS IN YOUR SHOULDER? YES OR NO
WHEN WAS YOUR LAST INJECTION? ___/___/___
HAVE YOU HAD PHYSICAL THERAPY FOR YOUR SHOULDER? YES OR NO
DID IT HELP? YES OR NO
HAVE YOU HAD ANY SPECIAL TEST ON YOUR SHOULDER? YES OR NO
IF YES, WHAT TEST? MRI CT SCAN EMG/NCS

DIAGRAM

LEFT HAND **RIGHT HAND**



Signature:_____ Date: _____

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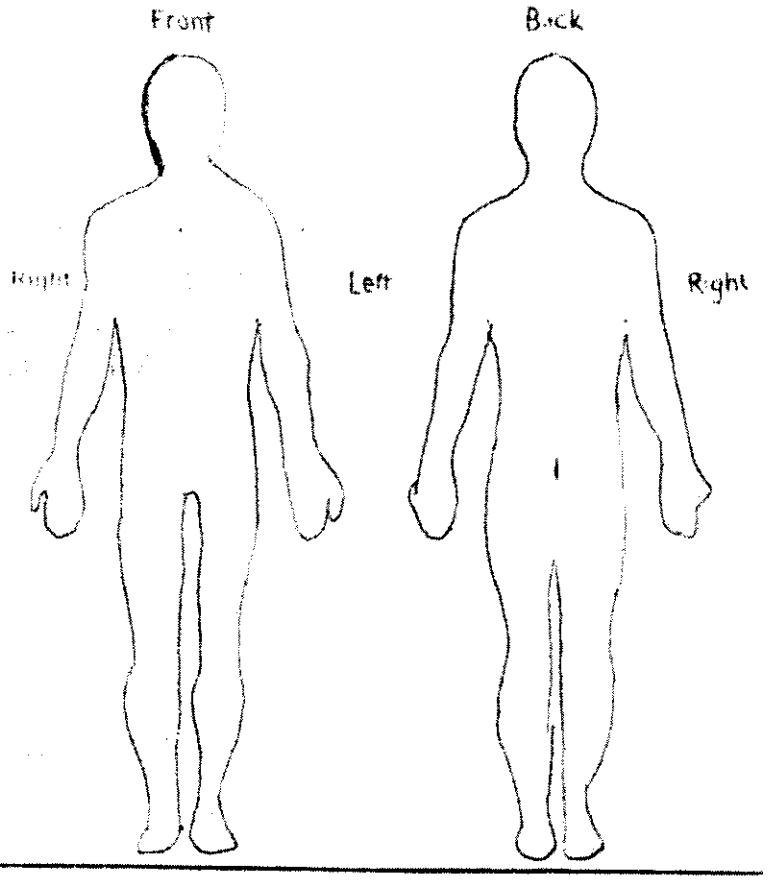
ONLY FILL OUT THE SECTIONS THAT APPLY TO YOUR SYMPTOMS

SPINE AND LOWER EXTREMITY

Where is your pain?	Lumbar Low Back	☐	Cervical Spine	☐	Thoracic Spine	☐
	Knee	☐	Ankle	☐	Foot	☐

Do you have Difficulty walking because of your problem?	YES or NO
Do you have to use an assist device to walk?	YES or NO
Do you have any numbness in your leg or arm or perineal areas?	YES or NO
Do you have any changes in bowel or bladder function?	YES or NO

If yes, since when. _____



Signature: _____ Date: _____

Patient Name: _____ DOB: _____ Sex:____M ____F

PCP: _____ Allergies: _____

PAST MEDICAL HISTORY: (Mark all that Apply)

____ No Major Problems
____ Heart Disease:____ Heart Attack _____ Pace Maker _____ Chest Pain _____ Heart Failure
____ High Blood Pressure:
____ Arthritis: Type:_____
____ High Cholesterol
____ Lung Disease: ____ Asthma ____ Bronchitis ___ Pneumonia ____ COPD ___ Emphysema___ TB___
____ Thyroid Disease:____ Hypothyroid ____ Hyperthyroid ____ Other
____ Kidney Disease:____ Kidney Failure ____ Dialysis _____ Kidney Stones____ Other_____
____ GI Disease:____ Ulcers ____ Gastric Reflux _____ Gastritis_____ Hiatal Hernia____ Crohns Disease
____GU Disease:____ Recurrent UTIs _____ Prostatitis _____ Other
____ Diabetes: ____ Take Pills _____ Take Insulin _____ Diet controlled
____ Psychiatric Disorder: ____ Depression ____ Anxiety ____ Other
____Neurological Disorder:____ Epilepsy(seizures) ____ Polio ____ RSD ____ MS____ Cerebral Palsy
____ Blood Transfusions: When and Why? _____
____ Blood Diseases: ____ Anemia _____ Hepatitis type_____ HIV_____
____ Cancer: When and Where? _____
Other Major/Chronic Problems: _____

PAST SURGICAL HISTORY: _____ **NONE (ONLY CHECK IF YOU HAVE NEVER HAD ANY SURGERY IN YOUR LIFE)**
List
Date/Procedure:_____
_____
_____

SOCIAL HISTORY:
Smoking: ____ No ____ Yes, packs per day:_____ how long?_____
Alcohol use: ____ No ____ Yes How much? _____
Drug Abuse: ____ No ____ Yes Substances used? _____
Advance Directives/Living Will: ___ No ____ Yes ____ copy in our file
FAMILY HISTORY:_____ Unknown _____ None

Review of Systems: Are you currently having any of these problems

General: Fever Chills Fatigue Weight Loss Weight Gain Poor appetite

HEENT: Stuffy Runny nose Sore Throat Earache Nose bleeds Visual Changes

Cardiac: Chest pain Tightness Pressure

Pulmonary: Cough Shortness of Breathe Wheezing

GI: Nausea Heartburn Cramps Constipation Diarrhea Blood in stool

GU: Pain Increased Frequency Blood Odor

Neuro: Headache Numbness or tingling Shaking Loss of balance

Psychiatric: Anxiety Depression

Ortho: New joint pains

Skin: Rash Lesions
Endocrine: Hot flashes Diabetes Thyroid

_____ ___/___/___
SIGNATURE: DATE:

UNIVERSAL MEDICATION FORM

Todays Date: _____

Name:	
Allergic To:	**Reaction:**
Allergic To:	**Reaction:**
Allergic To:	**Reaction:**
Allergic To:	**Reaction:**

List all Medicines you are currently taking: Prescription and Over the Counter

Date Prescribed:	Name of Medication:	Directions:	Prescribing Doctor:	Reason for Prescription:

Patient Registration Sheet

Last Name:_____ First Name:_____ M.I._____

Street Address:_____

City:_____ State:_____ Zip_____ DOB: _____

Phone Number:_____ home/Cell _____work

Sex: Male Female SS #: _____ Marital Status: Single Married Other

Employer :_____ Phone # _____

Insurance Company:_____ Policy #_____

Emergency Contact:_____ Phone # _____

Responsible Party Information

Relationship to Patient_____ If different please fill out the following information

Last Name:_____ First Name:_____ M.I._____

Street Address:_____

City:_____ State:_____ Zip_____ DOB: _____

Phone Number:_____ home/Cell _____work

Sex: Male Female SS #: _____ Marital Status: Single Married Other

Employer :_____ Phone # _____

Authorization to Release Information

I authorize release of information (including facsimile transmission) relative to my medical records and/or lab results to my referring physician _____, my spouse_____

and the following names only _____

Patient's or Authorized Persons Signature:

I authorize Dr. Sonya Clark to release any medical or other information necessary to process this claim. I also request payment of government benefits or other medical benefits assigned to Dr. Sonya Clark for any procedures and/or services rendered.

Signature:_____ Date: _____