Warren G. Kramer III, MD, Sten E. Kramer MD, Ryan S. Labovitch MD,
Jennifer A. Taylor MS, PA-C, Robin L. Ray MS, PA-C

Name: ____**Date of Birth:** _____/___/_____**Age:** _____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Sex: ❑F ❑M **Height**: ______**Weight**:______**Race**:__________**Ethnicity**:_________**Primary Language:** __________

Patient's Marital Status__________ **Nearest Relative**______________________

Patient's Address____**City**______________________**Zip**_______

Name of Responsible Party if Patient is a Minor____

Insurance____________________**Main subscriber on the insurance**___________________**DOB**____________

Patient SS#________________________**Home Phone** ( )________________**Cell**( )____________________

Email_________________________ **Patient's Employer** (If minor, Responsible Party) _______________________

Occupation________________**Work Address**______________________________**Work Tel** ( ) _____________

Spouse's Employer_____________________**Spouse's Name**________________**Work Tel** ( ) _____________

Referred here by (check one) ❑Self ❑Family ❑Friend ❑Doctor ❑Other Health Professional

Name of person making referral:____

Primary Care Physician/Internist: __________________________Cardiologist: _____________________________

(Would you like records sent to any of these Doctors? (Yes/No) **Please Circle One**

Have you had a recent medical evaluation by one of these doctors? _____Name of Doctor: ______________________

What is your primary problem for being seen today?

Where is your Pain? **Body Part:** ____**Right or Left (circle one)**

Length of Symptoms:_____________________ **Date of Injury**:____

Describe your injury and symptoms: ____

____

Does your pain **Radiate** up or down?	YES	NO	(If yes: up down both)
Do you have any weakness?	YES	NO	
Do you have **Numbness and/or tingling**	YES	NO	
Have you had **Surgery** on this body part?	YES	NO	
If yes, describe the procedure:	______________________________________		
Date(s) / Surgeon(s):	______________________________________		
Have you had **Physical Therapy**?	YES	NO	If yes, how many visits ____
Have you had any **Images** taken on this body part?	MRI CT EMG Bone Scan Xray (circle all that apply)		
	Findings:____		
Have you had an **Injection**(s)?	YES	NO	If yes, how many _____________________

What **Pain Medicine** are you taking for this problem? ____

Past Medical History:

In the past 4 weeks, have you had a cough, cold, sore throat or bronchitis that required treatment? ________________

List any medical conditions you have: (ex High blood pressure, mitral valve prolapsed)

____

Drug Allergies: Yes No **List allergies?** ____

Type of Reaction:____