

# Adult Medicine & Pain Management

1 Pinnacle Place, Ste. 203, Albany, NY 12203  
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## Patient Information Sheet

Please fill out and bring to your appointment

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HAIRCOLOR: \_\_\_\_\_ EYE COLOR: \_\_\_\_\_

Check One: Right Handed \_\_\_\_\_ Left Handed \_\_\_\_\_

DATE OF INJURY \_\_\_\_\_ CIRCLE ONE: AT WORK AUTO ACCIDENT OTHER

Did you go to the hospital? YES NO If so, when? \_\_\_\_/\_\_\_\_/\_\_\_\_

Did you have tests performed? YES NO If so, what? \_\_\_\_\_

Current Doctor: \_\_\_\_\_ Who referred you to your current doctor? \_\_\_\_\_

Are you taking medication? YES NO If so, what? \_\_\_\_\_

WERE YOU EMPLOYED AT THE TIME OF YOUR ACCIDENT/INJURY? YES NO

If so, where? \_\_\_\_\_ For how long? \_\_\_\_\_

What type of work did you perform? \_\_\_\_\_

Does this include (Circle ONE for each category)

HEAVY LIFTING	Regularly	Occasionally	Seldom	Never
LIGHT LIFTING	Regularly	Occasionally	Seldom	Never
SITTING	Regularly	Occasionally	Seldom	Never
WALKING	Regularly	Occasionally	Seldom	Never

Did you miss time from work? YES NO

Are you working now? YES NO Date returned to work: \_\_\_\_/\_\_\_\_/\_\_\_\_

If yes, are you performing your regular work? YES NO

Do you work somewhere else? YES NO If yes, where are you currently working? \_\_\_\_\_

Have you been injured at work before? YES NO

Have you been injured in a previous accident? YES NO  
If so, when?(List all dates) \_\_\_\_\_

Who did you treat with? (List all providers) \_\_\_\_\_

Have you ever had surgery? YES NO If so, when? \_\_\_\_\_ What was the surgery? \_\_\_\_\_

DO YOU PRESENTLY PERFORM:

Housework	YES	NO	Child Care	YES	NO	Yard Work	YES	NO	Shopping	YES	NO
Running	YES	NO	If yes, how far? _____	(Circle One)	DAILY	WEEKLY	SELDOM				
Walking	YES	NO	If yes, how far? _____	(Circle one)	DAILY	WEEKLY	SELDOM				
Aerobics	YES	NO	If yes, how far? _____	(Circle one)	DAILY	WEEKLY	SELDOM				

List all hobbies: \_\_\_\_\_

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_