INTEGRITY PAIN MANAGEMENT
KERRY C. LATCH, M.D. / CHRISTIAN SAMUELSON, M.D.

NAME: _____
DOB: _____

PERSONAL HISTORY

HEIGHT: _____ WEIGHT_____

DO YOU HAVE CHILDREN? _____ IF SO, HOW MANY _____

HAVE YOU HAD AN MRI X-RAYS EMG

1. Are you allergic to any medications: NO YES
List medications and type of reaction:
_____
_____
_____

4. **Do you take any prescription medication**? NO YES

LIST MEDICATIONS	DOSE	FREQUENCY	LAST DOSE	DO YOU TAKE ANY OTHER MEDICATION?
				NO YES IF YES, LIST BELOW

WORK HISTORY

WHO WAS YOUR EMPLOYER AT THE TIME OF THE INJURY
_____

WHAT WAS YOUR JOB DESCRIPTION _____

ARE YOU STILL EMPLOYED WITH THEM? YES OR NO

IF NOT ARE YOU CURRENTLY EMPLOYED? YES OR NO

I understand that I have been referred to Integrity Pain Management Center for the purposes of determining my present status. Any information obtained during my visit will be used to determine that status. I, therefore, will give the most complete and honest answers possible. I understand that physical testing is necessary and will give my best efforts during the tests.

SIGNATURE _____DATE: _____