

Name: _____

Date of Birth: _____

Today's Date: _____

Tell us about your symptoms.

What are your symptoms? _____

When did your symptoms begins? _____

How did they begin? _____

Is the pain constant, or does it come and go? _____

What makes the pain better? (rest, ice, heat, pills) _____

What makes the pain worse? _____

Do you have pain that radiates into the arm or leg?

() no () yes, describe _____

Have you lost control of your bowel/bladder?

() no () yes, describe _____

Do you have any weakness or numbness/tingling in an arm or leg?

() no () yes, describe _____

How long can you...
sit _____ stand _____ walk _____

Is your pain the result of a

() fall () auto accident () injury on the job

() other _____

Have you ever had back/neck problems before this injury?

() no () yes, describe _____

Employer at time of injury _____

Is there a lawsuit pending on this problem?

() no () yes

Who else has treated you for this problem? _____

Have you had physical therapy for this problem?

() no () yes, describe _____

Did this therapy help?

() no () yes, describe _____

Have you had injections for this problem?

() no () yes, describe _____

Did these injections help?

() no () yes, describe _____

Have you had? () chiropractic treatment () trigger point injections

() biofeedback () psychologic treatment () surgery

What tests have you had? () CT scan () MRI () x-ray () EMG

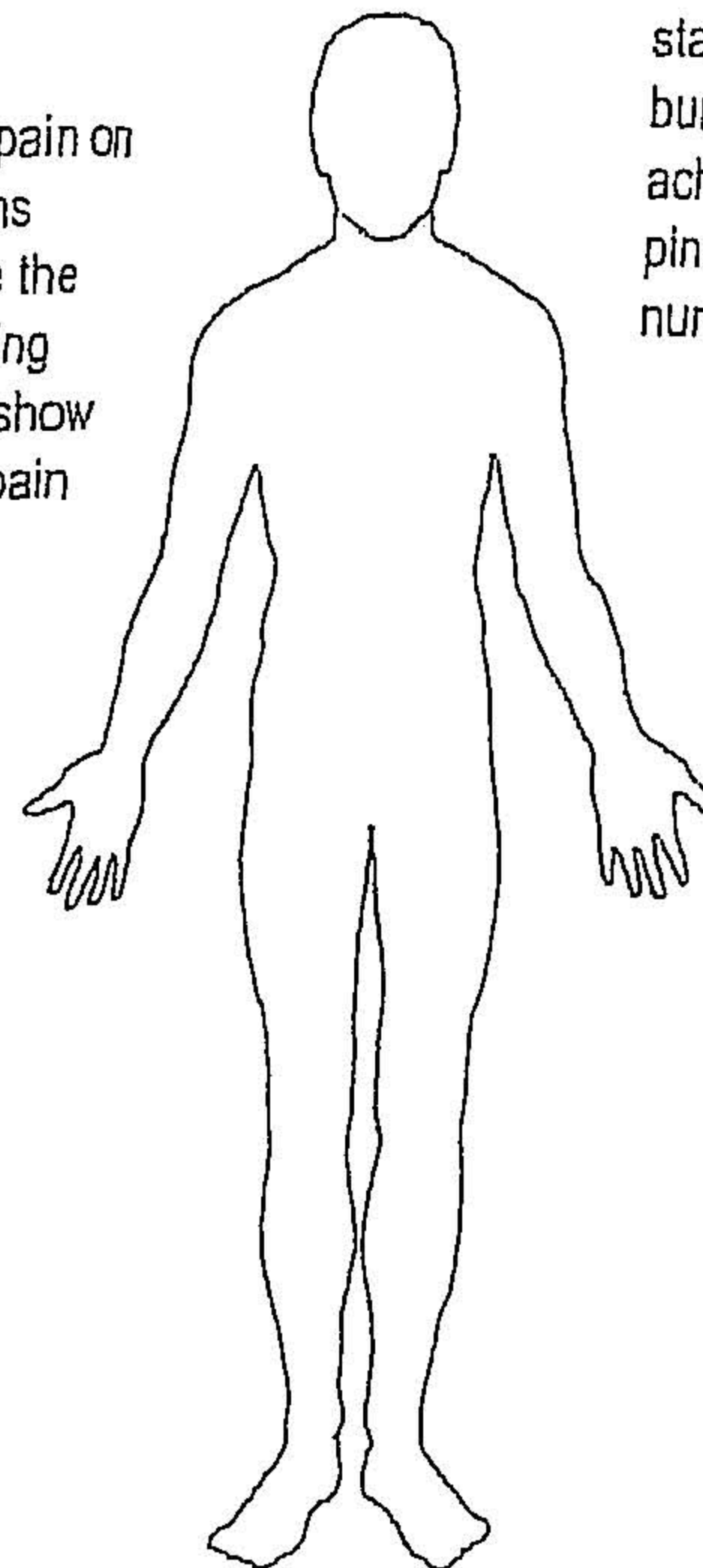
Other _____

What do you hope to accomplish today? _____

What other concerns do have? _____

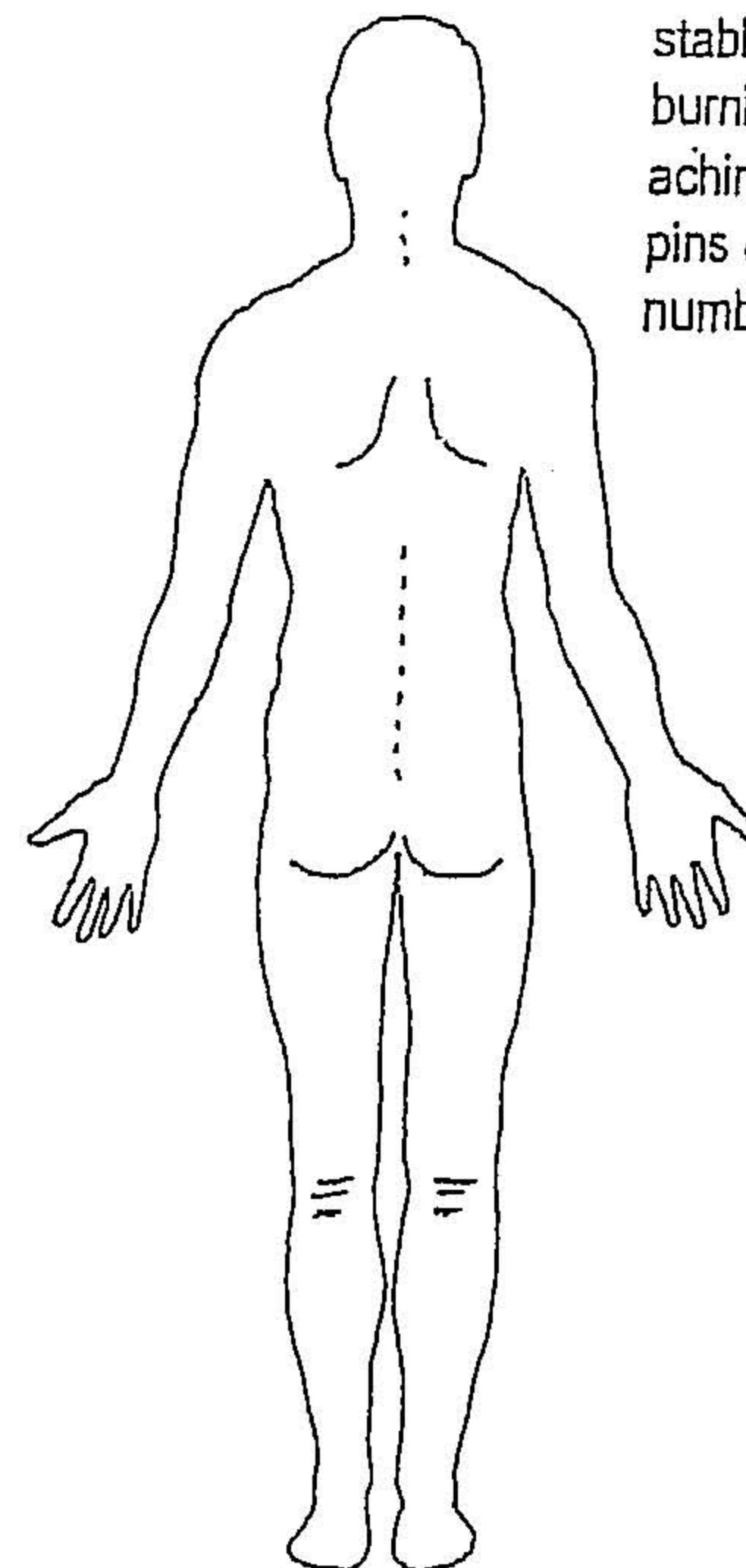
Front

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.



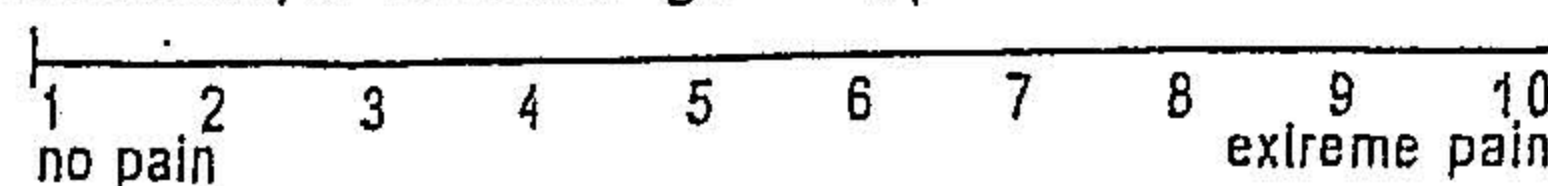
stabbing pain /////
burning pain ooo
aching pain xxx
pins & needles vvv
numbness ===

Back



stabbing pain /////
burning pain ooo
aching pain xxx
pins & needles vvv
numbness ===

Circle your pain level on a scale of 1 to 10, with 10 being unbearable, or worst imaginable, pain.



Name: _____ Date of Birth: _____ Today's date _____

Family History:

Do any of your grandparents, parents, siblings or children have any of the following diseases ? Explain.

Diabetes	No	Yes	_____
High Blood pressure	No	Yes	_____
Heart attack	No	Yes	_____
Cancer	No	Yes	_____
Arthritis	No	Yes	_____
Rheumatoid Arthritis	No	Yes	_____
Back or neck problems	No	Yes	_____
AIDS/HIV	No	Yes	_____
Bleeding disorders	No	Yes	_____
Epilepsy	No	Yes	_____
Hepatitis	No	Yes	_____
Migraines/Headaches	No	Yes	_____
Psychiatric problems	No	Yes	_____
Stomach	No	Yes	_____
Thyroid Problems	No	Yes	_____

Social History

single married divorced separated widowed

Do you live alone? No _____ Yes _____

employed (occupation _____) student retired

not working –because of: _____ Date last worked _____

Example: not working because of back or neck problem

Children ? No Yes # _____

Exercise ? never rarely weekly daily

What type of exercise? _____

Smoking ? No Yes _____ packs per day for _____ years

Alcohol? No Yes How much _____ How often _____

History of substance abuse ? No Yes What? _____

Do you use medical marijuana? No Yes

Patient Signature _____ Date: _____

MD Signataure _____ Date: _____