NAME: ______________________ **DATE:** ______________________

Age: __________ Gender: ☐Male ☐Female Hand Dominance: ☐ Right ☐ Left

Who referred you for evaluation? ______________________

Who is your primary doctor? ______________ Address: ______________

What is being examined today? ______________ Which side? (Right/Left) __________

DATE of accident, or How long have you had illness / problem / symptoms? __________

Please describe your injury: ______________________

SYMPTOMS:

Where is your pain? How long has it been there?

Location		Duration (wks / yrs)
☐ Head		______
☐ Neck		______
☐ Shoulder	L / R	______
☐ Arm	L / R	______
☐ Hand	L / R	______
☐ Mid Back		______
☐ Low Back		______
☐ Buttocks	L / R	______
☐ Hip	L / R	______
☐ Leg	L / R	______
☐ Foot	L / R	______

When having pain is it generally…

- ☐ Mild discomfort
- ☐ Dull, achy pain
- ☐ Hard, aching pain, frequently worse
- ☐ Severe pain, sharp/shooting at times
- ☐ Burning pain
- ☐ Very severe, sharp, stabbing
- ☐ Extremely disabling

How often are you having pain?

- ☐ Rarely, if ever
- ☐ Occasional (If so, how often? __________)
- ☐ Recurrent (few days every month)
- ☐ Frequent (more than half the time)
- ☐ Very frequent (nearly every day)
- ☐ Constantly

How much of your pain is in your neck/back and how much is in your arm/leg? (must total 100%)

_____% neck/back + _____% arm/leg = 100%

Rate your pain at is worst and at its best:
(0 = No pain, 10 = Worst imaginable pain)

0 1 2 3 4 5 6 7 8 9 10 at is worst

0 1 2 3 4 5 6 7 8 9 10 at is best

Have you experienced any of the following:

- ☐ Numbness / Tingling in arms; (L), (R)
- ☐ Numbness / Tingling in hands; (L), (R)
- ☐ Numbness / Tingling in legs; (L), (R)
- ☐ Numbness / Tingling in feet; (L), (R)
- ☐ Weakness in legs; (L), (R)
- ☐ Weakness in arms; (L), (R)
- ☐ Clumsiness of hands; (L), (R), (both)
- ☐ Balance problems
- ☐ Bladder problems: __________
- ☐ Bowel problems: __________
- ☐ Pain that wakes you from sleep (night pain)

What makes your pain better?

☐ Lying down	☐ Looking up/down
☐ Sitting	☐ Looking L / R
☐ Standing	☐ Bending Forward
☐ Walking	☐ Bending Backwards
☐ Lifting	☐ Sneeze / Cough
☐ Sleeping	☐ Twisting
☐ Ice	☐ Heat

☐ Other (please describe): __________

What makes your pain worse?

☐ Lying down	☐ Looking up/down
☐ Sitting	☐ Looking L / R
☐ Standing	☐ Bending Forward
☐ Walking	☐ Bending Backwards
☐ Lifting	☐ Sneeze / Cough
☐ Sleeping	☐ Twisting
☐ Ice	☐ Heat

☐ Other (please describe): __________

What time of day is your pain usually worst?

☐ Morning	☐ Same all day
☐ Mid-day	☐ At night
☐ Evening	

Describe the course of your condition as:

☐ Rapidly worse	☐ Rapidly better
☐ Slowly worse	☐ Slowly better
☐ Unchanged	

What treatment have you received?

☐ None	☐ Anti-inflammatory med
☐ Physical Therapy	☐ Muscle relaxants
☐ Chiropractic	☐ Narcotic medications
☐ Traction	☐ Epidural injections
☐ Acupuncture	☐ Other: ____________

What studies have been done on your spine?

☐ None	☐ X-rays
☐ MRI	☐ CT scan
☐ Myelogram	☐ Bone Scan
☐ DEXA Scan	☐ EMG

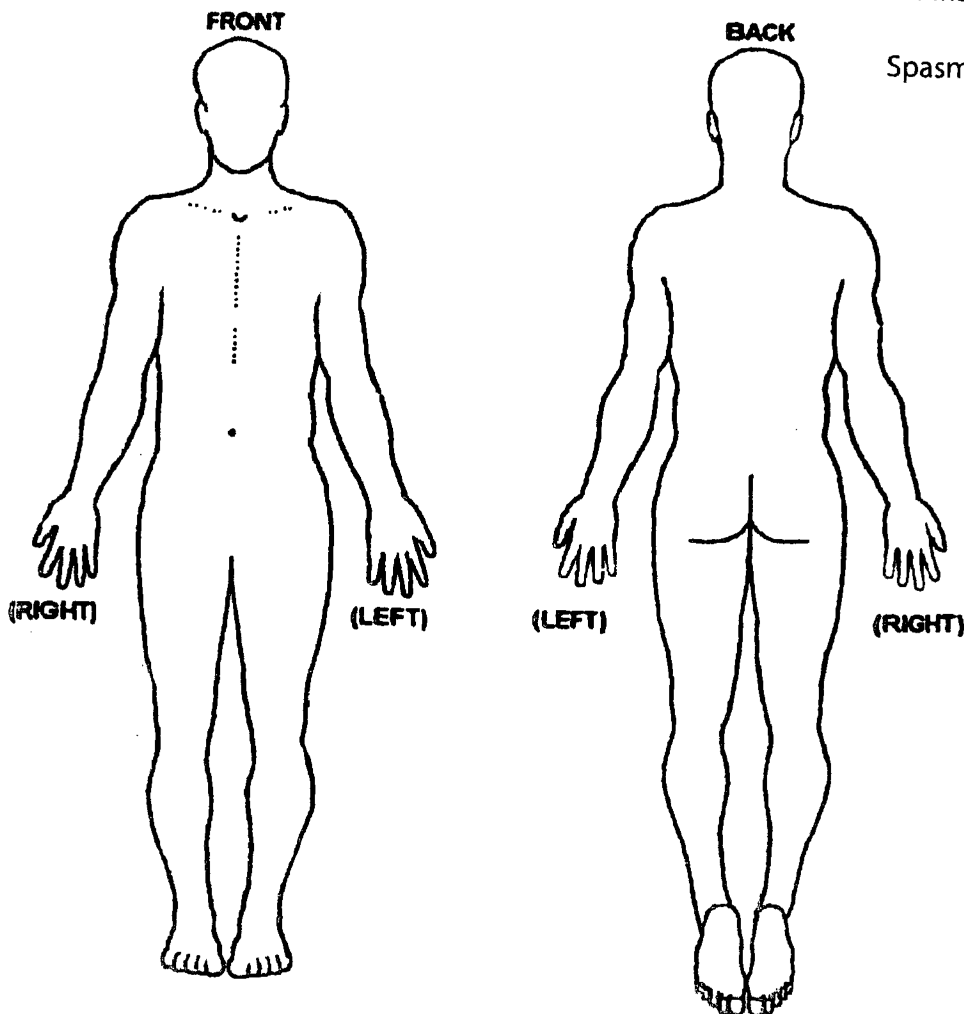
Have you had previous spinal surgery? ☐ No ☐ Yes   Did it help you? ☐ No ☐ Yes

If yes, what type of surgery, who was the surgeon and when was it done? ____________________

PAIN DRAWING:

Indicate where you are having symptoms by using the proper **symbols** and **arrows** to show where the pain goes or shoots. Be sure to show **ALL areas involved** and to indicate where the **PAIN IS WORST.**

Aching / Pain (X X X)
Numbness / Tingling (0 0 0)
Pins / Needle (::::::)
Burning (/////)
Spasm / Cramp (ΔΔΔ)



Please indicate that you have completed this form truthfully and as accurately as possible by signing below:

Signature   *Date*

PAST MEDICAL HISTORY:

Please rate your general health

- ☐ Excellent
- ☐ Fair
- ☐ Good
- ☐ Poor

What medical problems do you have?

- ☐ None
- ☐ Cancer (what type?) ____________
- ☐ Heart Disease
- ☐ Lung Disease (i.e. pneumonia, asthma, COPD)
- ☐ Liver Disease (i.e. jaundice, hepatitis)
- ☐ Diabetes
- ☐ High Blood pressure (hypertension)
- ☐ Rheumatic Fever
- ☐ High cholesterol
- ☐ Anemia or bleeding problems
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Urinary tract infections
- ☐ Other serious Health problems: ____________

____

PAST SURGICAL HISTORY:

Have you had any previous surgery?

- ☐ None
- ☐ Tonsillectomy
- ☐ Appendectomy
- ☐ Cholecystectomy (Gallbladder)
- ☐ Heart (bypass)
- ☐ Thyroid surgery
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ Knee Arthroscopy
- ☐ Pacemaker
- ☐ Cancer surgery (describe:) ____________
- ☐ Other (list:) ____________

MEDICATIONS: ☐ None

Please list all medications that you take and dose:

____

____

____

____

____

____

ALLERGIES: ☐ None

Please list all drug allergies and reactions:

____

____

____

SOCIAL HISTORY:

What is you occupation? ____________

Are you presently employed?

- ☐ Yes; where and for how long

____

- ☐ No; how long since you were

____

Are you married? ☐ Yes ☐ No

Who do you live with? ____________

Do you smoke?

- ☐ No
- ☐ Yes; ____________ packs per day
  ____________ years
- ☐ used to, but quit

Do you drink alcohol (beer, wine, liquor)?

- ☐ No
- ☐ Yes; how much/often?

____

FAMILY HISTORY:

Do any of the following medical problems run in your family? If so, please list family member:

- ☐ None
- ☐ Heart disease
- ☐ Diabetes
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Thyroid disease
- ☐ Renal (kidney) disease
- ☐ Pulmonary (lung) disease
- ☐ Liver disease
- ☐ Cancer
- ☐ Spinal stenosis
- ☐ Scoliosis
- ☐ Osteoporosis
- ☐ Other serious health problems; list:

____

____

Females only: Are you pregnant? ____________

What is your height? ____________

How much do you weigh? ____________

Review of Systems:

Please check and describe any signs or symptoms which you are currently experiencing from any of the following organ systems. If none, please write "NONE".
Please list any other problems you may be experiencing that you do not see listed.

Constitutional Symptoms:
☐ Fever ☐ Chills ☐ Night Sweats ☐ Weight Loss ☐ Fatigue ☐ Appetite loss

Eyes:
☐ Corrective lenses ☐ Cataracts ☐ Blurry Vision ☐ Double Vision

Ears, Nose, Mouth, Throat:
☐ Hearing loss ☐ Sinus Congestion ☐ Hoarse voice ☐ Painful/Difficulty swallowing

Cardiovascular (Heart, circulation):
☐ Chest pain ☐ Cool extremities (poor circulation) ☐ Cold sensitivity

Respiratory (Lungs):
☐ Shortness of breath ☐ Painful breathing ☐ Wheezing ☐ Cancer

Genitourinary (i.e. urinary tract infection, prostate):
☐ Urinary frequency ☐ Urinary incontinence ☐ Painful urination
☐ Sexual dysfunction ☐ Enlarged prostate ☐ Cancer

Gastrointestinal:
☐ Reflux ☐ Ulcers ☐ Cancer
☐ Diarrhea ☐ Constipation ☐ Bloody stool
☐ Nausea ☐ Vomiting

Musculoskeletal:
☐ Joint pain, where?____________
☐ Joint swelling
☐ Joint stiffness ☐ Fibromyalgia

Skin/Breast:
☐ Cancer, where?_______ what type?__________
☐ Lumps or masses, where? _________________
☐ Rashes

Psychiatric:
☐ Depression ☐ Manic
☐ Eating Disorder

Neurological:
☐ Stroke ☐ Trouble speaking ☐ Peripheral nerve disorder, list?__________________
☐ Balance problems ☐ Seizures ☐ Tremor ☐ Reflex Sympathetic Dystrophy

Endocrine:
☐ Diabetes ☐ Hypoglycemia ☐ Thyroid
☐ Parathyroid ☐ Adrenal ☐ Osteoporosis

Hematologic/Lymphatic:
☐ Anemia ☐ Clotting disorder
☐ Platelet disorder ☐ Sickle Cell
☐ Lymphedema
☐ Swollen lymph nodes, where?_________
☐ Tender lymph nodes, where?__________

Immunologic:
☐ Rheumatoid ☐ Lupus

____
Doctor's Signature (documenting review of above)

Financial Interest Consent

I, ____________________ (patient), acknowledge and accept that my physician may have a financial interest in hospitals, surgery centers, imaging centers, physical therapy and/or surgical devices that he/she chooses to utilize. I hereby recognize my right to choose another physician or request the services of another facility or device be used.

______________________ SIGNATURE

______________________ DATE