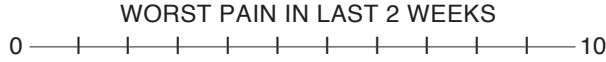
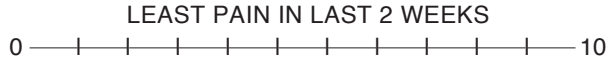
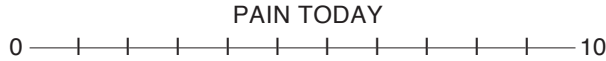


Rate your pain on this scale. (Mark with an X)

0 = No Pain 10 = Worst possible pain



Rate these activities on how your pain is affected:

	Better	Worse	No Difference
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Flat on Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Flat on Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Flat on Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Who else has treated you for this?

- Physical Therapist Chiropractor
 Other: _____

Rate these treatments on how your pain is affected:

	Better	Worse	No Difference
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you do back/neck exercises? Yes No

Do you do them daily? Yes No

Do you do aerobic exercise regularly? Yes No

Do you have any sleep problems? Yes No

If yes: How many hours do you sleep? _____

How many times do you awaken a night? _____

PREVIOUS BACK/NECK INJURY HISTORY

Have you ever had this exact injury before? Yes No
 If yes, did you have surgery? Yes No

Have you ever had a back problem before? .. Yes No

Have you ever had a motor vehicle accident? . Yes No

If yes, how many? _____

Was there litigation (lawyers) involved? Yes No

Have you ever filed a Workers' Comp claim? .. Yes No
 What part of the body was hurt? _____

Was there litigation (lawyers) involved? Yes No

Have you ever missed any work from a back or neck problem? Yes No

If yes, how much time? _____

Have you ever had back or neck surgery? Yes No

Date	Type of Surgery	Pain Better Afterward	Pain Worse Afterward

WORK HISTORY

Are you:

- Currently Working Permanently Disabled
 Retired Temporarily Disabled

Did you stop working because of your pain? .. Yes No

Current/Recent Employer: _____

Date of Hire: _____

Usual Occupation: _____

Physical Demands of Your Job

- Very Heavy (lift >100 lbs.) Heavy (lift > 50 lbs.)
 Moderate (lift > 30 lbs.) Light (lift 15-30 lbs.)
 Repetitive Hand Tasks Sedentary (No lifting)

Describe your job.

SOCIAL HISTORY

Marital Status

- Married
- Divorced
- Separated
- Widowed
- Live with significant other
- Never Married

HOW MANY TIMES?	HOW LONG?
_____	_____
_____	_____
_____	_____
_____	_____

How many children do you have and what are their ages?

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____
7. _____	8. _____	9. _____
10. _____	11. _____	12. _____

Habits: (Check if you have or have ever had the following habits.)

- Smoking Cigarettes: Age started _____ # of packs/day _____
 Quit: _____ (when)
- Cigars Marijuana Crank
- Pipe Cocaine Heroin
- Caffeinated Beverages (Coffee, tea, cola) # per day _____
- Drinking Alcoholic Beverages: Age started _____
 Last drink _____ (when) # of drinks/week _____
 Have you tried alcohol to help your pain? Yes No

EDUCATION:

What is your highest level of education or training?

GENERAL MEDICAL HISTORY

Who is your Primary Care Doctor?

What were the results?

Who referred you to us?

When was your last general physical?

Check if you have or had any of these medical problems:

- Heart Attack/Angina High Blood Pressure
- Stroke Diabetes
- Ulcers Thyroid Disease
- Kidney Disease Liver Disease
- Arthritis
- Cancer (type: _____)

When was your last rectal exam?

FEMALES:

When was your last pelvic exam, Pap smear, breast exam?

LIST ALL SURGERIES AND DATES (not spine related)

Type of Surgery	Date	Type of Surgery	Date

LIST ALL DRUG ENVIRONMENTAL AND FOOD ALLERGIES

LIST ALL MEDICATIONS YOU TAKE (Including nonprescription. {Check those meds that you take for your back/neck.})

Medication	Dosage	Medication	Dosage
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	

