


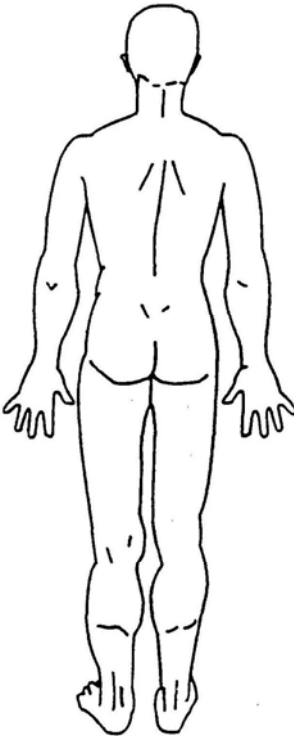
NAME	MEDICAL RECORD NUMBER	DATE
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MAIN PROBLEM: _____

How long has this problem been going on? ____Days ____Weeks ____Months ____Years (Fill in Number)

Do you have ideas or opinions on what caused your current problem?

Please place "XX" on the diagram below where you are experiencing pain.
Please place "OO" on the diagram below where you are experiencing numbness/tingling

FRONT		BACK	
			
Right	Left	Left	Right

Describe Your Pain:

<input type="checkbox"/> Throbbing	<input type="checkbox"/> Gnawing
<input type="checkbox"/> Shooting	<input type="checkbox"/> Heavy
<input type="checkbox"/> Stabbing	<input type="checkbox"/> Tender
<input type="checkbox"/> Sharp	<input type="checkbox"/> Splitting
<input type="checkbox"/> Cramping	<input type="checkbox"/> Fearful
<input type="checkbox"/> Burning	<input type="checkbox"/> Punishing
<input type="checkbox"/> Aching	<input type="checkbox"/> Sickening
<input type="checkbox"/> Tiring	<input type="checkbox"/> Cruel

What positions or activities make your main problem worse?

What positions or activities make your main problem better?

Circle one number that rates the average amount of pain that you have experienced **DURING THE PAST WEEK**

0 1 2 3 4 5 6 7 8 9 10

Over the past 7 days, how many good days have you had? _____ How many bad days have you had? _____

Please list all medications that you are taking, including vitamins and supplements

NAME OF MEDICATION	DOSAGE (Strength of each pill)	NUMBER OF PILLS PER DAY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ALLERGIES: _____

TREATMENTS TRIED

What have you tried for your symptoms? (Check all that apply and circle those that helped)

- Physical therapy Back class Acupuncture Chiropractic Traction
 Feldenkrais/Yoga Pilates Braces Chronic pain program Surgery
 Spinal injections Other

If you have checked "Other", please describe: _____

OCCUPATIONAL/LIABILITY

Is today's problem related to an on-the-job injury? Yes No Unsure

Have you filed a claim for today's problem with your employer? Yes No

Is today's problem related to a personal injury case or motor vehicle accident? Yes No Unsure

Do you have or anticipate litigation (lawsuit) regarding today's problem? Yes No Unsure

PAST MEDICAL HISTORY

Please list all of your medical problems:

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Pelvic pain |
| <input type="checkbox"/> Cancer (describe below) | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Neurologic disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Other (list below) |

Please list any psychiatric or psychological problems that you have experienced:

- | | | |
|---|----------------------------------|-------------------------------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> OCD | <input type="checkbox"/> ADD |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Bipolar | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Emotional, physical, or sexual abuse | | |

Please list all surgeries that you have undergone along with their dates:

FAMILY HISTORY (please list health problems that run in your family)

HABITS

Do you smoke cigarettes? Yes No _____ Packs/day How many years have you smoked? _____

Do you currently drink alcohol or have a history of doing so? Yes No
 Daily Socially

Do you currently use any recreational drugs or have a history of use? Yes No
How many caffeinated drinks (coffee, tea, soda, energy drinks) do you drink per day? _____

What recreational activities do you participate in?

- Weight training Swimming Jogging Exercise classes
- Exercise machines Bicycling Other (please list) _____

SOCIAL HISTORY

What is your marital status?

- Married/living with spouse Single/never married Divorced/separated
- Widowed Living with a significant other

What is your level of education?

- High school diploma/equivalent College degree or above Others _____
- WORK HISTORY**
- What type of work do you do? _____
- What is your current employment status?
- Currently working full-time Currently working part-time On modified work
 - Unemployed Full time student Part time student
 - Homemaker Retired Disabled
 - On sick leave
- If you are retired or on sick leave due to a disability, please list the nature of the disability and date of your retirement/sick leave:

- HEALTH QUESTIONS**
- Over the past 2 weeks, how often have you been bothered by any of the following problems?
- | | Not at all | Several days | More than half the days | Nearly every day |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Little interest or pleasure in doing things _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Feeling down, depressed, or hopeless _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Trouble falling or staying asleep, or sleeping too much _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Feeling tired or having little energy _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Poor appetite or overeating _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Feeling bad about yourself—or that you are a failure or _____
have let yourself or your family down | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Trouble concentrating on things, such as reading the _____
newspaper or watching television | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Moving or speaking so slowly that other people could _____
have noticed. Or the opposite—being so fidgety or
restless that you have been moving around a lot
more than usual | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Thoughts that you would be better off dead, or of _____
hurting yourself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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HEALTH QUESTIONS

Do you have any of the following?

- Fevers, chills, or night sweats _____ Yes No
- Recent unintended weight loss _____ Yes No
- Incontinence (loss of bladder or bowel control) _____ Yes No
- Numbness or tingling _____ Yes No
- Frequently drop things _____ Yes No
- Difficulty with balance or walking _____ Yes No
- Recent falls _____ Yes No
- Easy bleeding or bruising _____ Yes No
- Muscle cramping _____ Yes No
- All over muscle tenderness _____ Yes No
- Vision problems _____ Yes No
- Headaches _____ Yes No
- Problems with coordination (difficulty using your hands, stumbling) _____ Yes No
- Stopping breathing while you sleep _____ Yes No
- Reaction to contrast dye or iodine _____ Yes No

What activities are you having trouble doing because of this current problem? _____
