PATIENT HISTORY

List any **Allergies**:

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin □ Ragweed/Pollen

□ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye

□ Other: _____

List any **Surgeries**:

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist

□ Other: _____

List **ALL Past Medical History** conditions:

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Depression

□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain

□ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure

□ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain

□ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson's

□ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain

□ Stroke/Heart Attack □ Other: _____

Please list **ALL Medications** you are taking, the **amount**, and the **reason** for each one:

_____

_____

_____

_____

List your **Family History**:

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition

□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio

□ Prostate Problems □ Stroke/Heart Attack □ Other: _____

Have you had any auto or other accidents? □ No □Yes If yes, when? _____

Describe: _____

	Living/ Deceased	Heart Disease	Stroke	Cancer	Diabetes	Arthritis	Multiple Sclerosis	Lung Disease	Bone Disease
Father	**L D** Cause:								
Mother	**L D** Cause:								
Sibling **M** Child **F**	**L D** Cause:								
Sibling **M** Child **F**	**L D** Cause:								
Sibling **M** Child **F**	**L D** Cause:								
Sibling **M** Child **F**	**L D** Cause:								
Sibling **M** Child **F**	**L D** Cause:								
Sibling **M** Child **F**	**L D** Cause:								
Sibling **M** Child **F**	**L D** Cause:								

SOCIAL HISTORY

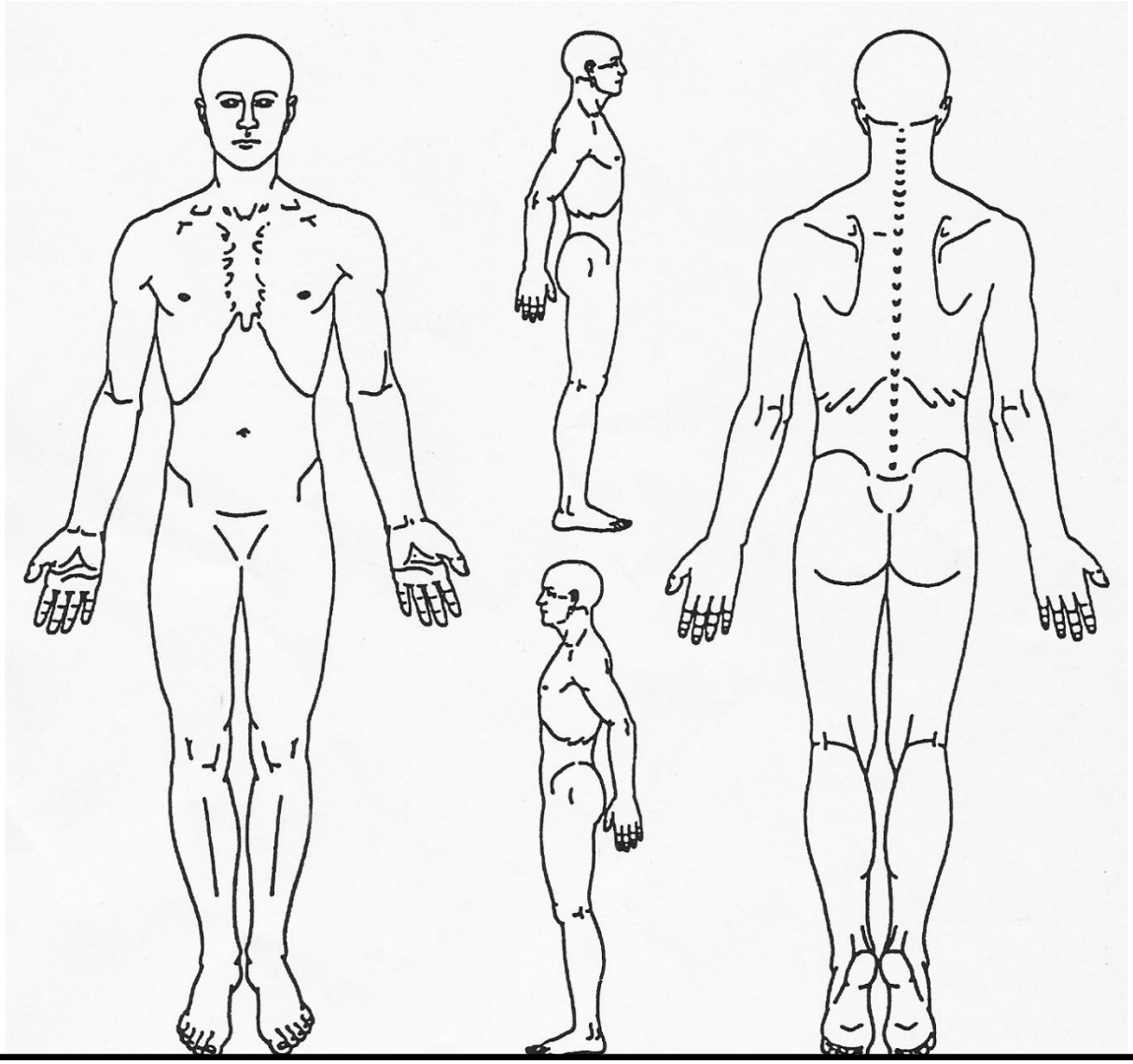
Do you smoke? □ No □ Yes
Do you drink alcohol? □ No □ Yes
If yes, how many per day? _____
Do you drink caffeine? □ No □ Yes
If yes, how many per day? _____
Do you exercise regularly? □ No □ Yes
Would you say that you sleep well? □ No □ Yes
Would you consider yourself stressed? □ No □ Yes

If yes, what is it caused from? _____

PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

Ache	**Burning**	**Radiating Pain**	**Dull Pain**
Numbness	**Stabbing**	**Pins & Needles**	**Other**



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

Place the number of how you would rate your pain next to each area of complaint on the diagram above.

How long have you experienced neck/back /other pain? _____ Years _____ Months _____ Weeks

Is this your first episode of neck/back/other pain? Y/N

SIGNATURE: _____ DATE: _____

What is your **FIRST** major complaint? _____When did it begin? _____

How did this problem begin (falling, lifting, etc.)? _____

Have you had this condition in the past? □ No □Yes

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other:_____

What makes your pain better (ice, heat, massage, etc.)_____

What activities aggravate your condition (working, exercise, etc.)?_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

What is your **SECOND** major complaint? _____When did it begin? _____

How did this problem begin (falling, lifting, etc.)? _____

Have you had this condition in the past? □ No □Yes

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other:_____

What makes your pain better (ice, heat, massage, etc.)_____

What activities aggravate your condition (working, exercise, etc.)?_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

What is your **THIRD** major complaint? _____When did it begin? _____

How did this problem begin (falling, lifting, etc.)? _____

Have you had this condition in the past? □ No □Yes

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other:_____

What makes your pain better (ice, heat, massage, etc.)_____

What activities aggravate your condition (working, exercise, etc.)?_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

What is your **FOURTH** major complaint? _____When did it begin? _____

How did this problem begin (falling, lifting, etc.)? _____

Have you had this condition in the past? □ No □Yes

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other:_____

What makes your pain better (ice, heat, massage, etc.)_____

What activities aggravate your condition (working, exercise, etc.)?_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)