



Name _____ Appointment Date _____
LAST FIRST MI

Age _____ Referring Doctor _____ Acct# _____ Auth# _____

Dominant Hand: Left Right Both Height: _____ft. _____inches Weight: _____ pounds

1. Briefly describe the reason for your appointment today: _____

2. Did your symptoms result from an accident? Yes No

3. If "Yes," list dates and nature of accident: _____

4. If "No," how long ago did your trouble begin? _____

5. List your most troubling areas in order (Most painful to least painful. Example: low back, hip, thigh)

6. For the MOST PAINFUL AREA, use a number "1" to mark this area on the body diagram on Page 2.

A) How would you describe the symptoms? (Check all that apply.)

- Dull Ache Sharp Ache Stabbing Tingling "Sleepy" Cramping Spasm Stiffness
- Popping Cracking "Giving Out" Hot Numb Burning Cold Chills
- Weak

B) Please check the severity of your symptoms in this area on an average day.

- Mild - no compromise of activities Slight - some compromise of activities
- Moderate - marked compromise of activities Severe - unable to perform most activities

C) Has this area been: improving getting worse staying unchanged

D) How frequent are the symptoms in this area?

- Occasional - less than half the day Intermittent - about half the day
- Frequent - more than half the day Constant - all day and every day

7. For the NEXT MOST PAINFUL AREA, use a number "2" to mark this area on the body diagram on Page 2.

A) How would you describe the symptoms? (Check all that apply.)

- Dull Ache Sharp Ache Stabbing Tingling "Sleepy" Cramping Spasm Stiffness
- Popping Cracking "Giving Out" Hot Numb Burning Cold Chills
- Weak

B) Please check the severity of your symptoms in this area on an average day.

- Mild - no compromise of activities Slight - some compromise of activities
- Moderate - marked compromise of activities Severe - unable to perform most activities

C) Has this area been: improving getting worse staying unchanged

D) How frequent are the symptoms in this area?

- Occasional - less than half the day Intermittent - about half the day
- Frequent - more than half the day Constant - all day and every day

8. For the NEXT MOST PAINFUL AREA, use a number "3" to mark this area on the body diagram below.

A) How would you describe the symptoms? (Check all that apply.)

- Dull Ache Sharp Ache Stabbing Tingling "Sleepy" Cramping Spasm Stiffness
- Popping Cracking "Giving Out" Hot Numb Burning Cold Chills
- Weak

B) Please check the severity of your symptoms in this area on an average day.

- Mild - no compromise of activities Slight - some compromise of activities
- Moderate - marked compromise of activities Severe - unable to perform most activities

C) Has this area been: improving getting worse staying unchanged

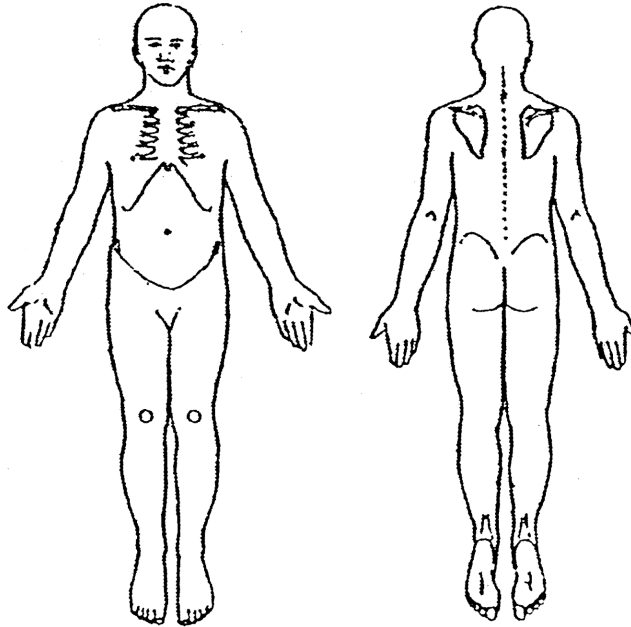
D) How frequent are the symptoms in this area?

- Occasional - less than half the day Intermittent - about half the day
- Frequent - more than half the day Constant - all day and every day

Body Diagram

Mark with a:

- "1" for most painful
- "2" for next most painful
- "3" for next most painful



9. Check all activities that increase your pain:

- Lifting** Over 50 pounds Over 25 pounds Over 10 pounds
- Standing** Over 1 hour Over 1/2 hour Over 10 minutes
- Sitting** Over 1 hour Over 1/2 hour Over 10 minutes
- Walking** Over 1 hour Over 1/2 hour Over 10 minutes
- Bending Forward** For prolonged time At all
- Twisting to the side Pulling Pushing Stooping Climbing ladder Climbing stairs
- Turning head to side Looking overhead Looking down Arising from a chair Lying down
- Sleeping Sneezing Coughing Straining Using left arm Using right arm Dressing
- Bathing Difficulty with Chore Hobby Sports other activity

10. List any position, activity, or treatment that decreases your pain: _____

11. Check any of these new problems that apply to you:

- Weakness in arms Weakness in legs Difficulty with balance Fevers Chills Sweats
- Loss of appetite Unexplained weight loss (more than 10 pounds) History of cancer Bladder problems
- History of steroid medications use Constipation Bowel problems Pain awakens me from sleeping

12. List doctors who have treated you in the past for this problem:

13. Check any diagnostic tests you have had in the past for this problem:

- X-rays CT (CAT) scan Magnetic imaging (MRI) Bone Scan Blood tests Nerve tests (EMG)
 Myelogram Nerve injection (nerve root block) Joint injection Discogram (X-ray exam of discs in your back)

14. Check any treatments you have had in the past for this problem:

- Bed rest Pain medications Muscle relaxants Heat Ice Massage Back brace
 Neck brace Magnets Pilates Herbal remedies Alternative clinic Traction / Inversion
 Biofeedback Acupuncture Chiropractic care Physical Therapy Personal fitness training
 Home Program Steroid (cortisone) injections Hospitalization Surgery Pain clinic

15. List any medical illnesses or conditions for which you are treated or have been treated in the past:

16. List all surgeries that you have had and approximate date. (Example: Hip replacement 1999)

17. List any allergies to medications and your reaction to them. (Example: Penicillin causes hives)

18. List all current medications that you take regularly, dosage and time you take it.

Medicine / Herb <i>Example: Motrin</i>	Dosage <i>800mg</i>	Frequency <i>1 pill at 8am, 1 pill at 6pm</i>
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19. List other substances:

Substance	Currently Use	Previously Used	How much?	How long?	When stopped?
<i>Example: Tobacco</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<i>1 pack/day</i>	<i>20 years</i>	<i>1982</i>
Caffeine: coffee, tea, soda	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<hr/>	<hr/>	<hr/>
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<hr/>	<hr/>	<hr/>
Alcohol: beer, wine, liquor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<hr/>	<hr/>	<hr/>
Recreation/Street Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<hr/>	<hr/>	<hr/>

20. Check any treatment complications that you have had:

- Allergic reaction (rash, hives, difficulty breathing) to Iodine Contrast dye Lidocaine Latex Penicillin
 Steroids or other medications Received blood transfusion Passing out with injection
 Infection in surgical incision Problems with anesthesia Bleeding problem after surgery

21. Please indicate your current work status:

Full time Part time Light Duty Disabled Unemployed Retired

22. Enter medical condition and ages for all family members:

Relative	Current age (or age at death)	Current medical conditions (or cause of death)
<i>Example: Father</i>	<i>82</i>	<i>deceased, cancer</i>
Father	_____	_____
Mother	_____	_____
Brothers/Sisters	_____	_____
_____	_____	_____
_____	_____	_____
Children	_____	_____
_____	_____	_____
_____	_____	_____
Spouse/	_____	_____
Significant Other	_____	_____

23. List your exercise program by activity and frequency: (Example- run 20 minutes 4 times a week)

24. List any hobbies: (Example- sewing, painting, gardening, carpentry, auto repair)

25. Are you involved in litigation? Yes No

26. Check any symptoms or conditions that you have recently had or now have

General Condition: Fever Chills Weight loss Weight gain Rashes Hives Easy bruising

Eye and Vision: Vision loss Eye pain Double vision

Ears and Hearing: Hearing loss Buzzing or noise in ears Ear drainage

Nose and Throat: Hoarseness Excessive sneezing Nosebleeds Difficulty swallowing Dentures

Respiratory: Wheezing Bloody or excessive sputum Chronic cough Pneumonia Emphysema
 Shortness of breath Painful breathing Night sweats Positive TB test

Cardiovascular: Chest pain Rapid heartbeat Abnormally low blood pressure Calf cramps with walking
 Swelling of ankles Chest palpitations High cholesterol

Gastrointestinal: Difficulty chewing Constipation Diarrhea Blood in stool Acid reflux Hemorrhoids
 Gallbladder trouble Abdominal pain Laxative use Nausea Vomiting Hepatitis

Urinary: Incontinence Blood in urine Painful urination Difficulty emptying bladder
 History of infections Excessive urine Kidney stones

Males: Erectile dysfunction Penile infection/sores Prostatitis Scrotal pain/swelling Sterility Painful intercourse

Females: Breast discharge, swelling, lumps, pain or infection Vaginal pain, infection, or discharge Infertility
 Uterine fibroid or tumor Tubal infection Abnormal menstrual flow Painful menses
 Painful intercourse Pregnancy complications

Neurological: Severe or frequent headaches Dizziness Fainting Seizures Limb paralysis
 Numbness or tingling Blackouts Memory lapses Head injury Polio Stroke

Emotional: Anger Depression Loneliness Hopelessness Helplessness Excessive worry
 Severe tension Recurrent fear or panic attacks Nervous exhaustion Frequent crying
 Insomnia Nervous breakdown Nightmares Unhappiness Irritability Alcohol use for pain
 Drug addiction Stress at home or work

Musculoskeletal: Broken bones Joint swelling Joint pain Dislocated joint Joint infection Bursitis Gout
 Tendonitis Torn cartilage Osteoporosis Torn muscle Torn ligament Ruptured disc Scoliosis

Other Conditions: _____