Name: ____________________________________ Date: _________________ Birthday: ___________

Age: _____ Height: _______ Weight: _______
If not referred, how did you choose this office? self family friend doctor attorney other

Please mark on the pain level that most accurately represents your pain

NO PAIN						UNBEARABLE PAIN					
	0	1	2	3	4	5	6	7	8	9	10
Today's Pain	0	1	2	3	4	5	6	7	8	9	10
Worst Pain…	0	1	2	3	4	5	6	7	8	9	10
Best Pain…..	0	1	2	3	4	5	6	7	8	9	10

HISTORY OF PRESENT ILLNESS:

1. What is the reason for your visit today?

2. How long have you had the problem?

   #___ days #___Weeks #___Mos #___Yrs

3. How severe is the problem?

4. Symptoms (specific problems)?

   ☐Sharp ☐Burning ☐Dull ☐Aching
   ☐Throbbing ☐Stabbing ☐Numbing
   ☐Sore ☐Pounding ☐Crampy ☐Tight
   ☐Electric ☐Crushing ☐Knot-Like ☐Pressing
   ☐Pinching ☐Pulsing ☐Pins and Needles
   ☐Prickling, ☐Shooting ☐Deep ☐Tender

5. How often do the symptoms occur?

6. How long do the symptoms last?
   ☐All day ☐All night ☐Position Change
   ☐ 24hours ☐ Other: list how below?

7. Does anything make the problem better?

8. Does anything make the problem worse?

9. Have you ever had treatment or surgery for this problem? ☐No ☐Yes

10. Is this a new pain/injury or an old chronic condition? ☐New ☐Flare up/Old

11. What started the pain/problem? ☐ I do not recall ☐Work Related ☐ ☐Non-work related

    Details:

12. Has the pain/problem worsened recently? ☐No ☐Yes, how recently? ____________________

13. Do you have night pain? ☐YES ☐NO

14. Does it waken you from sleep? ☐YES ☐NO

15. How often does the problem **flare up** occur? ___________ / N/A

16. Does the problem occur at a particular time of day? If so, when? ______________________________

17. Is the pain (check all that apply): ☐Continuous ☐Activity Related ☐Night Pain ☐Unpredictable

18. Have you already filed or will you file a Workers' Compensation claim? ☐YES ☐NO
    Litigation involved? ☐YES ☐NO

19. What other treatments have you tried?
    ☐Physical Therapy/Exercise ☐TENS unit
    ☐medications ☐Massage/Ultrasound
    ☐Traction ☐Anti-Inflammatories ☐Orthotics
    ☐Manipulation ☐Surgery ☐Steroid injections
    ☐Braces

20. I am ☐Left Handed ☐Right Handed ☐Ambidextrous

21. Occupation/Job? ______________________

22. Are you currently working?
    ☐Yes, Full-time ☐Yes, Part-time ☐No ☐N/A

23. Are you on modified duty? ☐ Yes ☐ No

Name: ____________________________________ Date: _________________ Birthday: ___________

List all SURGERIES, BIRTHS AND HOSPITALIZATIONS:

Year	Reason	Year	Reason

MEDICATIONS Have you had a trial of medications for **this** problem? ☐No ☐Yes . If yes, please list in the table below

MEDICATION NAME	DOSE (e.g., strength, # of pills or drops)	ROUTE (e.g., by mouth, injection, inhaled, or on skin)	FREQUENCY (how often)	FOR HOW LONG?	DID IT HELP
Example: Motrin	400 mg	By mouth	Once a day		

Have you had any imaging for this problem?

Date	CT/Xray/MRI	Where were these done?	Did you Bring them with you? Yes or No

MEDICATIONS Please fill in the table with medications that you are currently taking

NAME	STRENGTH	FORMULATION	FREQUENCY

Name: ______________________________ Date: _______________ Birthday: __________

ALLERGIES Please list any allergies to either medications (ie. Penicillin, sulfa) and/or non-medications (ie. shellfish, eggs, latex)

Agent	Reaction

Aggravates or Increases signs and symptoms: Choose each that apply

☐ Carry object, 100 feet	☐ Pushing	☐ Pulling	☐ Balance
☐ Climb up steps / stairs	☐ Turning neck R or L	☐ Lift; waist to shoulder	☐ Up/ down steps
☐ Crawling	☐ Handle/holding objects	☐ Finger/hand strength	☐ Hand coordination
☐ Exercising	☐ Crouch to retrieve	☐ Kneel to pray/retrieve	☐ Reach overhead
☐ From sitting to standing	☐ Concentrating	☐ Playing sports	☐ Stoop to retrieve
☐ Rolling over	☐ Watching TV	☐ Gardening/Yard work	☐ From standing to sitting
☐ Running	☐ Sleeping on back	☐ Sleeping on Right Side	☐ Sleeping on Left Side
☐ Sitting short time	☐ Bending forward at waist	☐ Dressing	☐ Reading
☐ Standing straight up	☐ Sitting for a long time	☐ Driving short distance	☐ Driving long distance
☐ Walking short distance	☐ Walking long distance	☐ Dancing	☐ Holding head down

What is the RATIO of neck pain versus arm pain? (ie. 80:20)_________ (Skip this section if no neck pain)

Neck Pain

I have neck pain in the ☐Middle of my neck ☐To the Right ☐To the Left ☐On both sides

Neck Symptoms are worse when ☐Sitting / Driving ☐Standing ☐Walking ☐Laying Down

Neck Symptoms are better when: ☐Sitting / Driving ☐Standing ☐Walking ☐Laying Down

Do you get headaches? ☐No ☐Yes . If yes, please describe them:

Arm / Shoulder Symptoms

I have pain in my	☐Right	☐Shoulder/Shoulder Blade	☐Elbow	☐Arm	☐Hand
	☐Left	☐Shoulder/Shoulder Blade	☐Elbow	☐Arm	☐Hand
I have numbness in my	☐Right	☐Shoulder/Shoulder Blade	☐Elbow	☐Arm	☐Hand
	☐Left	☐Shoulder/Shoulder Blade	☐Elbow	☐Arm	☐Hand
I have weakness in my	☐Right	☐Shoulder/Shoulder Blade	☐Elbow	☐Arm	☐Hand
	☐Left	☐Shoulder/Shoulder Blade	☐Elbow	☐Arm	☐Hand

Arm Symptoms are worse when ☐ Sitting / Driving ☐ Standing ☐Walking ☐Laying Down

Arm Symptoms are better when: ☐ Sitting / Driving ☐ Standing ☐Walking ☐Laying Down

I have noticed problems with:

☐ Gait / Walking / Balance

☐ Fine Motor coordination (using buttons, clasps, fine movements)

☐ Handwriting is sloppier

☐ Clumsiness, dropping things more frequently

☐ Bowel or bladder incontinence

Additional comments about your neck and upper back pain.

Name: ____________________________________ Date: _________________ Birthday: ___________

What is the RATIO of back pain versus leg pain? (i.e. 80:20)_________

Leg Pain

I have pain in my ☐ Right ☐ Buttocks ☐ Leg ☐ Calf ☐ Foot
☐ Left ☐ Buttocks ☐ Leg ☐ Calf ☐ Foot

I have numbness in my ☐ Right ☐ Buttocks ☐ Leg ☐ Calf ☐ Foot
☐ Left ☐ Buttocks ☐ Leg ☐ Calf ☐ Foot

I have weakness in my ☐ Right ☐ Buttocks ☐ Leg ☐ Calf ☐ Foot
☐ Left ☐ Buttocks ☐ Leg ☐ Calf ☐ Foot

Leg Symptoms are worse when ☐Sitting / Driving ☐Standing ☐Walking ☐Laying Down

Leg Symptoms are better when: ☐Sitting / Driving ☐Standing ☐Walking ☐Laying Down

Back Pain

I have back pain in the ☐ Middle of my back ☐Mid-back ☐Lower-back
☐To the Right ☐To the Left ☐On both sides

Back Symptoms are worse when ☐Sitting / Driving ☐Standing ☐Walking ☐Laying Down

Back Symptoms are better when: ☐Sitting / Driving ☐Standing ☐Walking ☐Laying Down

I have noticed problems with: ☐ Gait / Walking / Balance
☐ Bowel or bladder incontinence

Additional comments about your back and leg pain.

Prior Symptom History

Prior Similar Symptoms

___ I have not had prior symptoms similar to my current complaints

___ My current complaints DID exist before, but have not been bothering me

___ My current complaints ALREADY existed and were worsened

Has your history contributed to your current symptoms?

___ My history HAS contributed to my current symptoms.

___ My history HAS NOT contributed to my current symptoms.

___ I'm NOT SURE if my history has contributed to my current symptoms

The above information is complete and factual: ________________________________ ________________
(Patient/Parent/Guardian signature) (Date)