

Name _____ Date _____

1. Please Describe Your Complaint(s); if more than one, please number them according to severity: _____

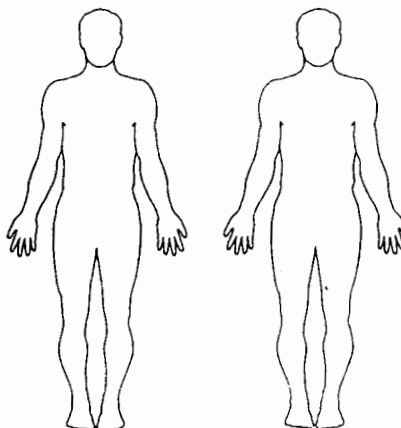
a. Description (What does it feel like?):
Please Number according to complaints.

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

- | | |
|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp Pain | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Dull Pain | <input type="checkbox"/> Gripping |
| <input type="checkbox"/> Ache | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Weak | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Stiff |
| <input type="checkbox"/> Numb | <input type="checkbox"/> Pulsing |

Front

Back



b. Frequency (How often does it occur?):

- | | |
|---|---|
| <input type="checkbox"/> Constant (76-100%) | <input type="checkbox"/> Occasional (26-50%) |
| <input type="checkbox"/> Frequent (51-75%) | <input type="checkbox"/> Intermittent (25% or less) |

c. Intensity: Circle the # that best describes your overall level of discomfort

No Pain [0] [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] Unbearable Pain

2. a. How long has your problem been present? days wks mnths yrs. Has it decreased not changed increased?

b. If it followed a specific incident, please date & describe: _____

c. If from lifting, how many lbs? ____ In what position were you? Bent forward Bent backwards Knees bent Twisted
Did you lift once a few times many times? Do you repeat the same motion often? Yes No

3. What doctors/providers have you seen for this episode? DC MD DO PT Currently seeing? DC MD DO PT

a. Examinations included: X-rays ___/___/___ MRI ___/___/___ CT ___/___/___ Other _____
Date Date Date Date

Comments _____

b. Treatment has included: Exercise Heat Cold Medications Support Electrical Therapy Manipulation Surgery
Comments _____

4. In the past have you been treated for the same or similar problem? Yes No If yes, when? _____

Type of provider seen? DC MD DO PT _____

5. What makes your problem better? Lying down Walking Standing Sitting Movement/Exercise Inactivity
 Medication, type _____

6. What makes your problem worse? Lying down Walking Standing Sitting Movement/Exercise Inactivity
 Medication, type _____

7. How would you rate your general stress level? Little or No Stress Minimal Stress Moderate Stress Greatly Stressed

8. Physical activity at work: Sitting more than 50% of workday Light physical work Manual labor Heavy manual labor
 Repeated Motion describe (specific) _____

9. General Physical Activity: No regular exercise program Light exercise program Moderate exercise program
 Strenuous exercise program describe (specific) _____

10. Does your complaint affect your ability to work or otherwise be active? (Check any that apply).

- No effect Need limited assistance with common everyday tasks. Cannot perform work duties as of ___/___/___ (date)
 Need assistance often. ___/___/___ (date) Unable to function without assistance. ___/___/___ (date)

PLEASE TURN TO SECOND PAGE FOR ADDITIONAL HEALTH QUESTIONS AND YOUR SIGNATURE

If you have ever had a listed symptom in the *Past*, please check that symptom in the *Past* Column. If you are presently troubled by a particular symptom, check that symptom in the *Present* column.

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (date) _____
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke (date) _____
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Swelling, Stiffness of Joint(s)	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders)
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Liver / Gallbladder problems
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gain <input type="checkbox"/> Loss	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis			
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue			
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstral Flow			
<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstral Flow			
<input type="checkbox"/>	<input type="checkbox"/>	Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps			
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis			
<input type="checkbox"/>	<input type="checkbox"/>	PMS			
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control			
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination			
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination			
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/irregular bowel habits			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing			
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion			
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash			

If a family member has had any of the following, please mark the appropriate box:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Chronic Back Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic Headaches
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lupus
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> High Blood Pressure	

Yes **No**
 Do you have a permanent disability rating?
 Location _____
 Date rating received ____/____/____
 Rating Percentage _____%

Present Weight _____ pounds Height _____ feet _____ inches

Please check any of the following that apply to you

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, # births _____	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills, type _____	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Medications (list if not listed elsewhere) _____	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
			<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffinated Soft drinks: cups/cans per day _____
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations/Surgical Procedures (list if not described elsewhere) _____			

Patient's Signature: _____ Date: ____/____/____

Doctor's Comments

