

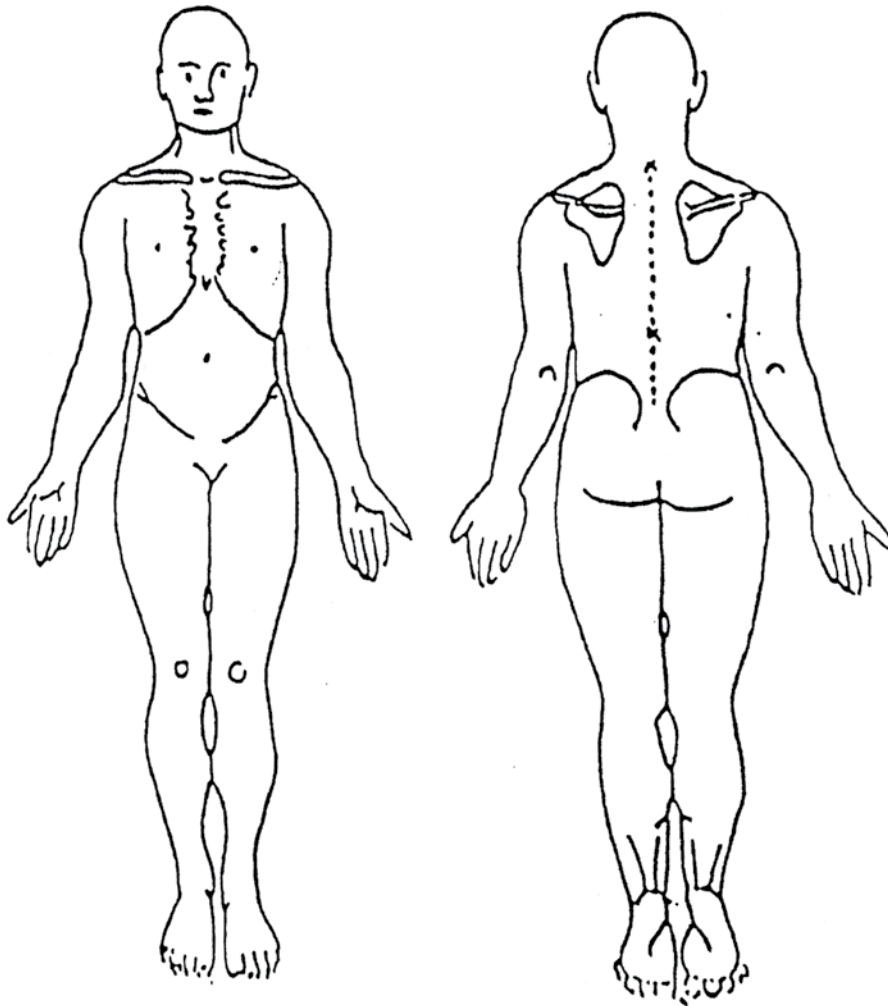
Using the symbols below, please draw in the location of your symptoms on the diagrams.

X = pain

O = Numbness

/ = Aching

★ = Pins & needles



If you have **NECK PAIN**, what percentage of your pain is _____% Neck and _____% Arm (Total 100%)

If you have **BACK PAIN**, what percentage of your pain is _____% Back and _____% Leg (Total 100%)

Mark an **X** on the line indicating the usual degree of the pain (0 = no pain and 10 = the worst pain)

0	1	2	3	4	5	6	7	8	9	10
Least Pain										Worst Pain

What position/activity makes the pain worse/better?

	Better	Worse	Comments
Bending			
Bowel Movement			
Coughing			
General Activity			
Home Remedies			
Lying Down			
Sitting			
Standing			
Walking			

How long can you **STAND** with no or minimal pain? _____ minutes.

WALKING DISTANCE with no or minimal pain:

0-50 ft
 50-200 ft
 200-500 ft
 500+ ft
 ½ mile +

Do you need **SUPPORT** to help you walk? Y N

If yes, what kind of brace? _____

List below the **PREVIOUS PHYSICIANS** (MD, DO, Chiropractor) you have seen for your main complaint/problem.

Physician	Specialty	Dates	Treatment

Indicate which **DIAGNOSTIC TESTS** you have had in evaluation of your main complaint/problem. (include dates)

Test	Date	Test	Date	Test	Date
Plain X-ray		EMG/NVC/SSEP		CT Scan	
Bone Scan		Arthrogram		Dexa Scan	
Myelogram		MRI		Diskogram	
Other:					

Please check which **TREATMENTS** you have had for your main problem/complaint and indicate whether they were helpful.

Treatment	√	Helpful?	Treatment	√	Helpful?	Treatment	√	Helpful?
Electric Stimulation			Massage			Whirlpool		
T.E.N.S.			Pool Exercises			Injections		
Ultrasound			Home Exercises			Acupuncture		
Hot Packs			Manipulation			Cold		
Other:			Botox					

PAST MEDICAL HISTORY Check below if you have had any of the following:

	√	Comments		√	Comments
Bowel Disorders			Osteoporosis		
Cancer (where?)			Pacemaker		
Depression			Polio		
Diabetes			Psoriasis		
Heart Disease			Rheumatoid Arthritis		
High Blood Pressure			Seizures		
High Cholesterol			Serious Infection		
Kidney Disease			Stroke		
Lung Disease			Thyroid		
Multiple Myeloma			Ulcers		
Other:					

List any **SURGERY OR SURGERIES** you have had.

Type	Date	Outcome

DRUG ALLERGIES

Drug	Type of Reaction

List **ALL CURRENT MEDICATIONS** as follows:

Name	Dose (milligrams, grams)	How Often (how many times a day)	How Long

Have you taken any of the following drugs previously?

Medication	√	Helpful?	Medication	√	Helpful?	Medication	√	Helpful?
Aspirin			Kadian			Skelaxin		
Bextra			Lortab			Soma		
Celebrex			Mobic			Topamax		
Clinoril			Motrin			Tylenol		
Darvocet			Naprosyn			Tylenol #3		
Demerol			Neurontin			Tylox		
Dilaudid			Oxycontin			Valium		
Dolobid			Parafon Forte			Vicodin		
Duragesic			Percodan			Vioxx		
Elavil			Prednisone			Zanaflex		
Flexerin			Prozac					
Ibuprofen			Relafen					

SOCIAL HISTORY & HABITS

Occupation: _____ Marital Status: _____ Highest Education Level: _____

WORK STATUS

Full duty Light duty Off duty per physician Unemployed Retired

If you are **NOT** working a full duty, how long have you been off work? _____

Have you had a work capacity assessment? Yes No

Are you disabled through Social Security? Yes No

TOBACCO USE

Do you currently use tobacco products? Yes No Started Age/Year: _____ Stopped: _____

If yes, indicate quantity per day: Cigarettes: _____ Cigars: _____ Chewing Tobacco (snuff): _____

ALCOHOL USE

Do you currently consume alcoholic beverages? Yes No

If yes, indicate quantity per day: Beer: _____ Wine: _____ Distilled spirits: _____

Have you been treated for drug or alcohol addiction? Yes No

REVIEW OF SYSTEMS

Check if you have experienced any of the following:

Constitutional	√	Eyes, Ears, Nose, Throat	√	Respiratory	√
Weight gain – last 6 months		Recent changes in vision		Short of breath	
Weight loss – last 6 months		Recent changes in hearing		Cough	
Night sweats		Recent changes in smell		Sputum	
Chills		Recent changes in taste		History of tuberculosis	
Fever		Dizziness		Wheezing	
Gastrointestinal		Genito-Urinary		Central Nervous System	
Nausea		Blood in urine		Poor appetite	
Vomiting		Urinary tract infections		Problem sleeping	
Diarrhea		Unable to control bladder		Numbness/tingling feet	
Indigestion		Unable to control bowel		Numbness/tingling hands	
Abdominal pain		Rushing to go		Crying spells	
Bloody or dark stools		Need to go frequently		Convulsions	
Cardiovascular		Musculoskeletal		Skin	
Chest pain		Cramps		Easy bleeding	
Palpitations		Attack of weakness		Any rashes	
Shortness of breath with exercise		Joint pain/swelling		Easy bruising	
Heart murmur		Morning stiffness			
Feet edema					

FAMILY HISTORY Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc.

	Age	Alive	Deceased	Medical history or cause of death
Father				
Mother				
Sibling 1				
Sibling 2				
Sibling 3				
Sibling 4				
Sibling 5				
Sibling 6				

FEMALE PATIENTS

	Date		Date
Abnormal vaginal bleeding		History of breast biopsy	
History of nipple discharge		History of endometriosis	

Date of last **MENSTRUAL PERIOD** _____

MALE PATIENTS

	Date		Date
History of prostatitis		Difficulty urinating	

Date of last **PROSTATIC EXAM**

Rectal test Yes No Results: _____

PSA (Prostate blood test) Yes No Results: _____

The preceding patient information packet has been reviewed and discussed with my patient.

PHYSICIAN SIGNATURE _____ Date _____