Patient Name ______________________________ **Date** ______________

Gender: M / F **Age** ____________ **Referring Physician** ______________________

Referring Physician's Address ______________________________

Date of Accident / Injury ______________________________

Date of Onset of Symptoms ______________________________

1) CHIEF COMPLAINT

______ Neck ______ Shoulder (R / L) ______ Hip (R / L)

______ Mid Back ______ Elbow (R / L) ______ Knee (R / L)

______ Lower Back ______ Wrist / Hand (R / L) ______ Leg / Thigh / Calf / Foot (R / L)

2) HISTORY OF PRESENT ILLNESS

A) Type of Injury

______ No Specific Injury ______ Work Accident ______ Slip / Fall ______ Lifting Injury

______ Hit Head (Loss of Consciousness? Y / N) ______ Trip / Fall ______ Hit by Object

______ Twisting Injury ______ Bruising (Area: ________________)

Other (Explain in Detail) ______________________________

B) Types of Treatment since Injury

______ No Treatment ______ Tens ______ Physical Therapy ______ Chiropractic Treatment

______ Injections ______ Epidurals ______ Nerve Block ______ Lumbar Brace / Corset

______ Cervical Collar ______ Extremity Brace

Other Treatment ______________________________

C) Are you involved in Litigation due to pain? YES / NO

D) Medication Taken for Symptoms?

______ Anti-Inflammatories ______ Pain Medication ______ Antidepressants

______ Medication for Sleep ______ Anxiety Medication ______ Medication for Spasm

List all other medications ______________________________

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E) Did you have surgical treatment for area of today's visit? YES / NO

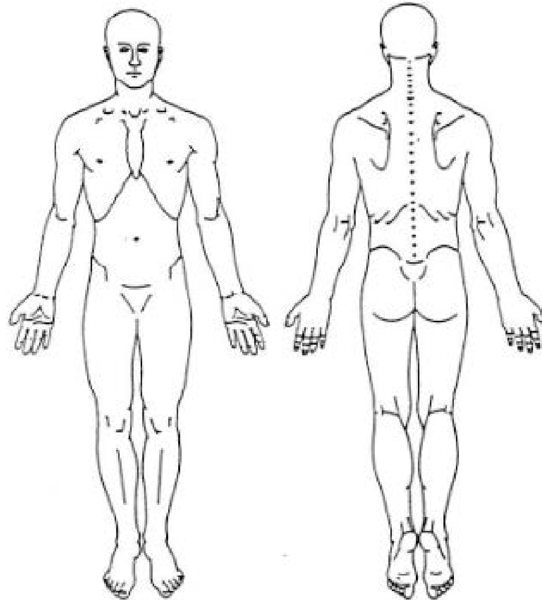
Type of Surgery ____

F) Circle or Indicate Level of Pain

Severity:	No Pain		Mild		Moderate		Severe		Excruciating		
	0	1	2	3	4	5	6	7	8	9	10

Use the figures below to mark the areas of present symptoms

Aching (+++) **Numbness (^^^)** **Pins and Needles (OOO)** **Burning (- - -)** **Stabbing (XXX)**



RIGHT / LEFT LEFT / RIGHT

1) Check all factors that describe your pain QUALITY

_____ Throbbing _____ Sharp _____ Cramping _____ Dull _____ Comes and Goes

_____ Shooting _____ Burning _____ Tingling _____ Aching

_____ Torturing _____ Nagging _____ Constant _____ Radiating

Patient Name ____________________________________ **Date** ____________________

2) Put a "B" or "W" for all factors that make your pain BETTER (B) or WORSE (W)

______ Standing ______ Heat Pack ______ Sleeping ______ Sitting
______ Bending ______ Walking ______ Stairs ______ Touch
______ Lying Down ______ Emotional Stress ______ Sexual Activity ______ Urination
______ Moving from Standing to Sitting ______ Menstrual Cycle

3) Check all factors that are IMPAIRED or made WORSE due to your present problem

______ Endurance / Tolerance for Activity ______ Ability to Focus and Concentrate
______ Level of Anxiety and Hopelessness ______ Postural Tolerance
______ Doing Home Chores ______ Daily Activities
______ Strength

Do you Exercise? YES / NO If **NO**, why not? ______________________________

3) FAMILY / SOCIAL / MEDICAL HISTORY

A) Family History: Any Family Health Problems (Brother, Sister, Parents)?

______ None ______ High BP ______ Diabetes ______ Heart Attack
______ Cancer ______ Arthritis ______ High Cholesterol ______ Heart Disease
______ Back Problems ______ Chronic Pain ______ Depression

B) Social History

Employed	______ No	______ Yes
Working	______ No	______ Yes
Drink Alcohol	______ No	______ Yes
Illegal Drug Use	______ No	______ Yes
Substance Abuse Treatment	______ No	______ Yes
Smoker	______ No	______ Yes

Type of Work (Occupation) ______________________________

Patient Name ______________________________ **Date** ______________

Education Level ______ High School Graduate ______ GED Diploma
______ College Graduate Degree ____________________
______ Did Not Complete School Grade Level _________

C) Medical History

1) List all Drug Allergies ____

2) Medical Health Problems?

______ Good Health ______ High Blood Pressure ______ High Chloesterol ______ Asthma
______ Diabetes ______ Kidney Disease ______ Heart Problems ______ Arthritis
______ Lung Disease ______ MV Prolapse ______ Liver Problems
______ Stomach Problems ______ Glaucoma ______ Bleed Easily

3) List all Current Medications (Prescription and Over-the-Counter)

____

D) Surgical History

List all Past Surgeries ____

4) GENERAL REVIEW OF SYMPTOMS

A) Any ill feelings recently? YES / NO

______ Good Health ______ Fever ______ Chills ______ Fatigue
______ Loss of Appetite ______ Loss of Energy ______ Major Weight Loss or Gain
______ Decreased Activity Level ______ Night Sweats ______ Uncontrolled Sweating

B) Mental Health problems? YES / NO

______ No Problems ______ Depression ______ Disturbed Sleep ______ Suicidal Thoughts
______ Irritability ______ Anxiety ______ Nervousness

Patient Name ____ **Date** ________________________

C) Trouble with Urination? YES / NO

_____ Frequent Urination _____ Urgency _____ Trouble Stopping / Starting
_____ Hesitancy _____ Nocturia _____ Burning with Urination
_____ Erectile Dysfunction _____ Bowel Dysfunction _____ Losing Control
_____ Sexual Dysfunction

D) Trouble with Vision? YES / NO

_____ Blurred Vision _____ Double Vision _____ Vision Loss _____ Eye Pain _____ Use Glasses

E) Any symptoms of Heart Trouble? YES / NO

_____ Chest Pain _____ Palpitations _____ Shortness of Breath
_____ Ankle Swelling _____ Fainting

F) Any Breathing problems? YES / NO

_____ Cough _____ Wheezing _____ Shortness of Breath

G) Any Stomach problems? YES / NO

_____ Nausea _____ Vomiting _____ Diarrhea _____ Constipation _____ Loss of Bowel Control

H) Muscle or Joint problems? YES / NO

_____ Joint Pain _____ Muscle Cramps _____ Muscle Weakness

I) Any Skin problems? YES / NO

_____ Rash _____ Itching _____ Dryness _____ Lesions _____ Open Wound / Infection
_____ Hair / Nail Change

J) Any Neurological problems? YES / NO

_____ Seizures _____ Numbness _____ Loss of Memory

Patient Name ______________________________ **Date** ______________

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K) Have you noticed these problems? YES / NO

______ Anemic ______ Cold / Heat Intolerance ______ Abnormal Bleeding / Bruising

L) Have you experienced these problems? YES / NO

______ Enlarged Lymph Nodes ______ Hives ______ Hay Fever ______ Persistent Infections

Patient Name ____ **Date** ________________________