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Patient Name (print)_____Date:_____

Height:_____Weight:_____Date of Birth:_____Age:_____

Are you currently employed? If yes, what is your occupation?_____

Is today's appointment related to: ○ Auto Accident ○ Workman's Compensation ○ Disability ○ Other_____

Are you experiencing any pain today? _____

When did your pain problem/injury first occur? _____

How long have you had this problem?_____

How would you describe the type of pain?

○ Sharp ○ Numb ○ Dull ○ Tingly ○ Diffuse ○ Achy

○ Sharp with motion ○ Shooting with motion ○ Stabbing with motion ○ Shooting

○ Stiff ○ Electric like with motion ○ Throbbing ○ Other_____

What makes your pain worse? (ex: daily work activities, exercise, stress)_____

_____

What makes your pain better? (ex: over the counter medication, splints, compression bandages)

_____

_____

Are you experiencing any increase in weakness as a result of your injury/pain problem?

_____

_____

Have you noticed an increase in clumsiness? (ex: tripping, dropping items) If yes, please explain:

_____

_____

Have you lost control of your bowels and/or bladder as a result of your injury? ○ Yes ○ No

Are there certain times during the day or certain daily activities that increase the amount of pain you are experiencing? (ex: pain is the worst after waking up in the morning.)

_____

_____

Do you have trouble getting to sleep because of your pain? ○ Yes ○No

Can you sleep through the night? ○ Yes ○ No

If no, I sleep a total of _____hrs./night and wake up _____times/night due to pain.

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Please list the exact types of tests you have received in relation to your pain problem/injury:

Test:	Date performed:	What hospital/clinic:	Findings:
X-Ray (what body part)			
CT (CAT Scan)			
MRI			
Bone Scan			
EMG			
Other tests:			

Please list all of the medications you currently take for any reason:

Drug Name:	Drug Dose:	Frequency:

Do you take any vitamins, herbs, or supplements? If yes, please explain:

_____
_____
_____
_____

Do you incorporate any type of splints/braces or any other type of modalities to help with pain? If yes, please explain:

_____

_____

Please list the exact types of pain injection therapy you have received (ex: epidural/cortisone injections):

Type of pain injection therapy:	Date performed:	Performing physician:

Have you had any type of surgeries or any other types of invasive procedures performed in relation to this problem? If yes, please explain:

_____
_____

How long have you been an employee at your current job?_____

In the past, have you experienced any other sort of injury or pain problem as a result of your daily work activities?

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Are you on any type of restricted work duties at work? If yes, please explain: _____

_____

_____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Do you have children? ○ Yes ○ No

Do you engage in any of the following?

○ Tobacco Use ○ Alcohol Use ○ Drug Dependence

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present	
○	○	Headaches	○	○	Mid Back Pain
○	○	Neck Pain	○	○	Low Back Pain
○	○	Upper Back Pain	○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain	○	○	Wrist Pain
○	○	Hand Pain	○	○	Hip Pain
○	○	Upper Leg Pain	○	○	Arthritis
○	○	Asthma	○	○	Rheumatoid Arthritis
○	○	Abdominal Pain	○	○	Dermatitis/Eczema/Rash
○	○	Joint Pain/Stiffness	○	○	Heart Attack
○	○	Liver/Gallbladder Disorder	○	○	High Blood Pressure
○	○	Heart Attack	○	○	Chest Pains
○	○	Stroke	○	○	Smoking/Tobacco Use
○	○	Kidney Stones	○	○	Bladder Infection
○	○	Painful Urination	○	○	Hepatitis
○	○	Ankle/Foot Pain	○	○	Cancer
○	○	Chronic Sinusitis	○	○	Drug/Alcohol Dependence
○	○	Prostate Problems	○	○	Abnormal Weight Gain/Loss
○	○	Muscular Incoordination	○	○	Visual Disturbances
○	○	Diabetes	○	○	Excessive Thirst
○	○	Frequent Urination	○	○	Allergies
○	○	Angina	○	○	Depression

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Past	Present		Past	Present	
○	○	Systemic Lupus	○	○	Epilepsy
○	○	HIV/AIDS	○	○	Knee Pain
○	○	Jaw Pain	○	○	Tumor
○	○	Loss of Appetite	○	○	Ulcer
○	○	Dizziness	○	○	General Fatigue

Are you currently pregnant? _____ If yes, how many months? _____

Indicate if you have any immediate family members with any of the following:

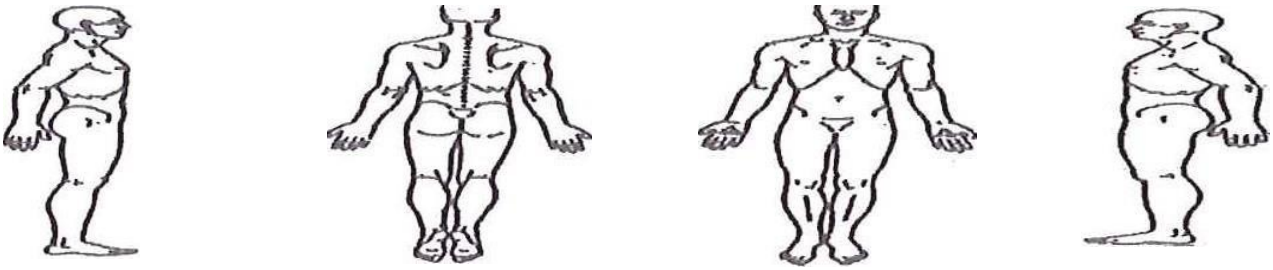
○ Rheumatoid Arthritis ○ Diabetes ○ Lupus ○ Heart Problems ○ Cancer

○ ALS ○ Stroke

If you have any immediate family members with any other chronic illnesses or debilitating diseases, please list them here:

_____
_____
_____
_____
_____

Indicate on the drawings below where you have pain/symptoms.



How often do you experience your symptoms?

○ Constantly (76-100% of the time) ○ Occasionally (26-50% of the time)

○ Frequently (51-75% of the time) ○ Intermittently (1-25% of the time)

How did it happen? Please check one: ○ Accident at work ○ Accident at home ○ Following surgery

○ Auto Accident ○ Following Illness ○Other_____

Have you ever had this pain before? If yes, explain:_____

How are your symptoms changing with time? ○ Getting worse ○ No change ○ Getting better

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Using a scale from 0-10 (10 being worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

What activities do you do at work?

○ Sit:	○ Most of the day	○ Half of the day	○ A little of the day
○ Stand:	○ Most of the day	○ Half of the day	○ A little of the day
○ Computer work:	○ Most of the day	○ Half of the day	○ A little of the day
○ On the phone:	○ Most of the day	○ Half of the day	○ A little of the day
○ Use hand/power tools:	○ Most of the day	○ Half of the day	○ A little of the day

Please list any other job duties or frequent daily activities you think might have contributed to your injury/pain problem (ex: washing dishes, folding clothes, using a cell phone, sitting at a desk, using mouse/keyboard, writing, using hand/power tools):

_____

_____

_____

How much has the problem interfered with your work?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

How much has the problem interfered with your social activities?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

○ Do you consider this problem to be severe?

○ Yes ○ Yes, at times ○ No

How would you rate your overall health? ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

What type of exercise do you do? ○ Strenuous ○ Moderate ○ Light ○ None

Who else have you seen for your problem?

○ Chiropractor ○ Neurologist ○ ER Physician ○ Orthopedist ○ Massage Therapist

○ Physical Therapist ○ Other_____ ○ No one

I certify that the above information provided in this form is correct to the best of my knowledge:

Patient Signature:_____