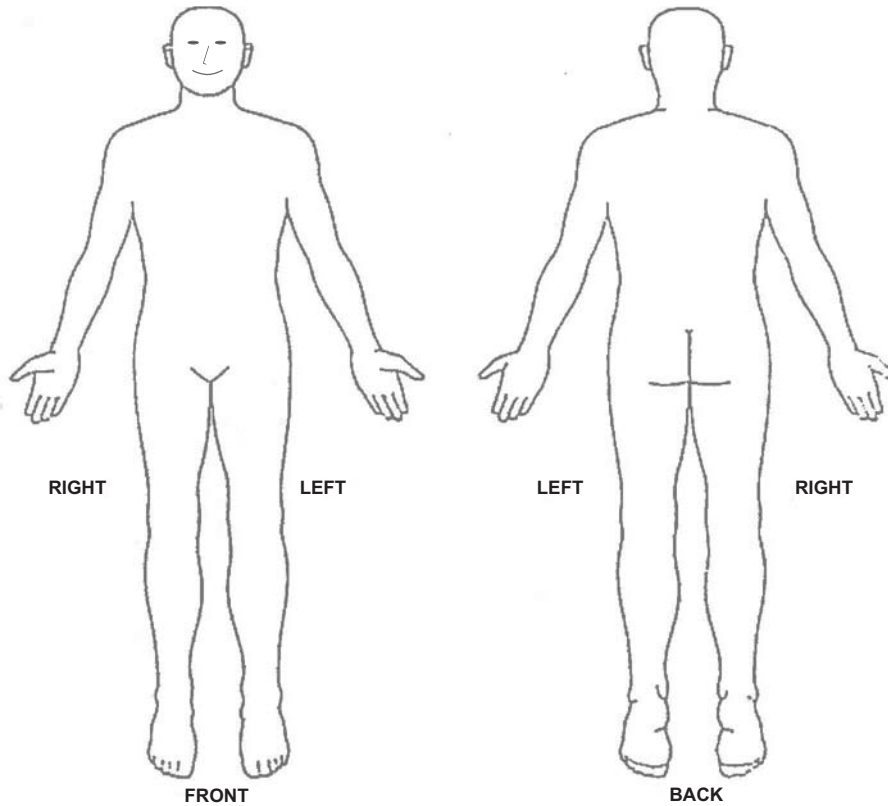


Patient Name: _____ Sex: F M Today's Date: _____
 Primary Care Physician: _____ Age: _____ Dominant Hand: R L
 Reason for visit: _____

Please indicate where you are having pain or numbness:



X = pain or ache
O = numbness or tingling

When did the pain start? _____ **Have you had a problem like this before? Y N**

In this section, check the box which best describes how your problem started. Please answer the questions related to the box you checked.

NO INJURY Was the onset **Gradual** **Sudden**

INJURY **Accident** **Sport**

Date: _____ Please specify where and how it happened.

What sport? _____ School? _____

INJURY AT WORK Date: _____ (please describe)

Lift Twist Fall Bend Pull Reach Repetitive

AUTO ACCIDENT (See box on next page)

Comments:

Answer the following ONLY if your pain is related to a Motor vehicle accident:

Accident date: _____

Location: _____

Were you: The driver? The passenger? In the backseat? In the front seat?
 Other, Describe _____

Were you wearing a seatbelt? Yes No Did airbags deploy? Yes No

About how fast was your vehicle moving? _____

If another vehicle was involved, about how fast was this vehicle moving? _____

Did you strike your body against the inside of the vehicle? If yes, describe: _____

Did you lose consciousness? Yes No

When did you first receive any medical attention? _____

When did back and/or neck pain start? _____

Was your car totalled? Yes No

Were you able to drive yourself from the scene? Yes No

Were police on the scene? Yes No

Were you taken to the hospital by ambulance? Yes No

All Patients Answer:

The pain is: Constant Intermittent (comes & goes)

On a scale of 0-10, 10 being the worst, how would you rate your pain?

Right now? _____ At its worst? _____ At its least? _____ Average intensity over past week? _____

What is the quality of the pain? Sharp Dull Stabbing Throbbing Aching Burning

Since my problem started, it is: Getting better Getting worse Unchanged

What aggravates the pain?: Walking Standing Sitting Getting out of chair Lying down

Cough/Sneeze Bending forward Bending backward Twisting Lifting Climbing stairs

Other _____

What makes the pain better?: Walking Standing Sitting Getting out of chair Lying down

Bending forward Bending backward Twisting Lifting Climbing stairs

Other _____

Please indicate if you had any of these in the past 30 days:

Fever or chills Numbness or tingling in arm or leg Weakness Unintentional weight loss over 5 pounds

Loss of bladder or bowel control Pain wakes you from sleep Pain/tingling below elbow or knee

What Treatments have you had for this problem?:

Ice or heat Anti-inflammatory medication (e.g.: Advil, Aleve, Motrin, etc)

Glucosamine Tylenol/acetaminophen Cane, walker, or wheelchair

Brace Narcotics (Vicodin, Hydrocodone, Oxycontin, etc.) Medrol dose pack

Seen a chiropractor? Used a TENS unit? Had injections? Had surgery?

Physical Therapy, If YES, when & where did you go and for how long? _____

of visits _____

Were you seen in the E. R. for this problem?: Yes No **Which E.R.?** _____

What test scans have you had for this problem? MRI CAT Scan **Where?** _____

Medications: List all over the counter and prescription medications you currently take and indicate amount and number of times taken per day

Surgical History: Please list prior surgeries.

Year:	Procedure:	Year:	Procedure:

Are you Allergic to any medications, Yes No Please list _____

Latex Allergy: Yes No **Iodine, or Contrast Dye Allergy:** Yes No

Past and Present Medical Problems: If yes, check box and specify:

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Epilepsy/Seizures _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> HIV or AIDS _____ | <input type="checkbox"/> Blood Clot _____ |
| <input type="checkbox"/> Gout _____ | <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Kidney Disease or Dialysis _____ |
| <input type="checkbox"/> Neuropathy _____ | <input type="checkbox"/> Thyroid Disease _____ | <input type="checkbox"/> Ulcers or Acid Reflux _____ |
| <input type="checkbox"/> Bleeding Disorder _____ | <input type="checkbox"/> Other _____ | <input type="checkbox"/> None |

Review of Systems:

Have you ever had any of these symptoms? If no, check NONE

- | | | |
|---|---|---|
| <input type="checkbox"/> Nausea, Vomiting | <input type="checkbox"/> Blood in Stool | |
| <input type="checkbox"/> Heat or Cold Intolerance | | |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Vision Loss |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Trouble Swallowing |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations | |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine | |
| <input type="checkbox"/> Frequent Rashes | <input type="checkbox"/> Skin Ulcers | <input type="checkbox"/> Lumps <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Anemia | |

Details/Comments

Are you pregnant? Y N

Are you claustrophobic? Y N

Family History:

Have any direct relatives had any of the following disorders? If so, list your relative. _____

- Diabetes _____ High Blood Pressure _____ Rheumatoid Arthritis _____
- Difficulty with anesthesia _____ Bleeding Problems _____
- Back pain / problems _____ None known _____

Social History:

Do you use tobacco? Y N, If yes, packs per day _____ Quit **Informed of Smoking Risk?** Y N

Alcohol use? Y N Quit

Marital History: Married Single Divorced Widowed

Are you currently working? Y N Retired Homemaker Disabled

If no, when did you last work? _____

Are you currently on any work restrictions? Y N, If yes, what are they? _____

If not working because of health problems, describe _____

If you are not, how long have you been restricted _____

Occupation: _____ Employer: _____ Student

Expectations:

Describe the activities involved in your job or the job you hope to return to: (Check all that apply)

- | | | | |
|------------------------------|------------------------------|-----------------------------|---|
| Relief from pain symptoms | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Does not apply |
| Return to your job | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Does not apply |
| Return to leisure activities | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Does not apply |
| Improved sleep | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Does not apply |

Describe the activities involved in your job that you have now, or hope to return to: (check all that apply)

- Heavy/frequent lifting Prolonged sitting or driving Pushing/pulling Prolonged standing

The following are activities you might do in a typical day.

Does your back or neck pain limit you in these activities? If so how much?

	Yes, limited a little	Yes, limited a lot	Not limited at all
Strenuous activities ... like running, lifting heavy objects	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Moderate activities ... like housework, pushing a vacuum, playing golf	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Lifting or carrying groceries	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Climbing several flights of stairs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Walking for 30 minutes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting for 30 minutes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Standing for 30 minutes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Getting dressed, bathing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

We may have staff call you to follow up on your symptoms and check to see how you are doing 3 months from now.

Is it okay for us to call you at the number you provided on the front side of this form? Yes No

How did you first hear about us? Friend/Relative / Word-of-Mouth Newspaper / Magazine

Internet/Website Health Insurance Directory Yellow Pages/Phone Book Dr. _____

For Office Staff Use

Vitals Signs: Height _____ Weight _____ BMI _____

Temp _____ Pulse _____ Resp _____ BP _____ O2 Sat _____

M.D. Signature

Date