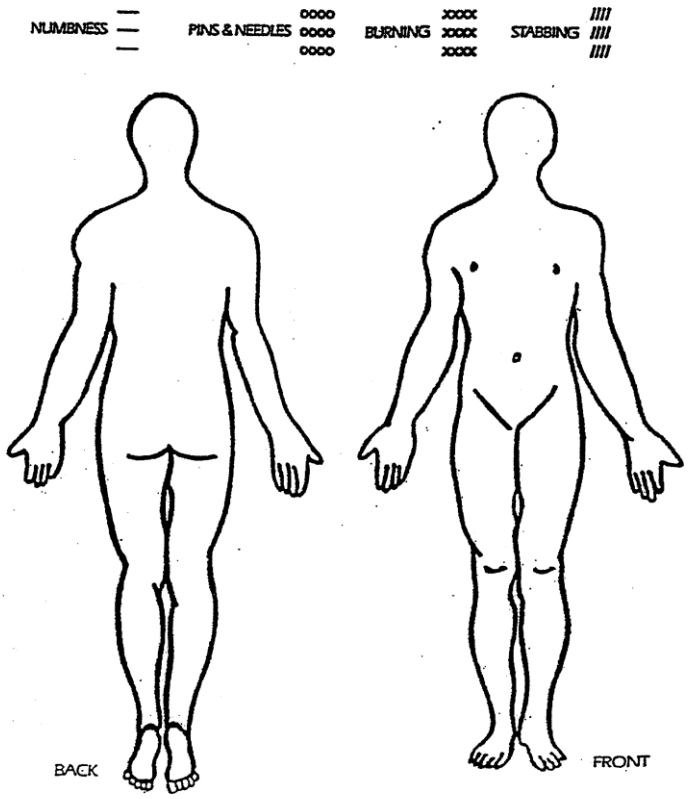
Name: _____Referring Doctor/Referring source: _____
Date: _____ Age: _____
Please fill out **ALL** of the following applicable sections:

- What is the **reason for today's visit**? What hurts?:

- **When** did your symptoms start?

- **How** did your symptoms start? (See below right if applicable):

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas. Just to complete the picture, please draw your face.



Car Accident: (circle appropriate answer and/or fill in blank)
Driving or passenger front/back seat?
Wearing seatbelt? Yes / No
Loss of consciousness? No/Yes How long?: _____
Briefly describe circumstances (i.e. Rear-ended while at stop light, struck stationary car, etc.): _____
_____
_____
Hospitalized? No / Treated and released from ER /Yes, for how long?

How long after the accident did you symptoms start? (immediately, 2 hrs, next day, etc.): _____

Work-Related injury:
Briefly describe incident (Lifting object, fell landing on buttocks, etc.)

How would you describe your job?:

What are the physical requirements/demands of your job?:

How long have you been with this employer?
What is your current work status? Not working because of this injury / Full Duty / Light duty: Lifting limit___ lbs. Other limitations: _____
_____

- **Please mark your level of pain on the scale below:**

Example: _____I_____

no pain — worst pain imaginable

Right now: _____

no pain — **worst pain imaginable**

At its worst: _____

no pain — **worst pain imaginable**

- Can you find a position where you are **free of pain** (i.e 0/10 pain)? No Yes - Please describe:

- Since your pain started it has been (check all that apply):
  - ❑ Constant
  - ❑ Intermittent
  - ❑ Waxing/Waning
  - ❑ Worsening
  - ❑ Without change
  - ❑ Improved
  - ❑ Resolved
  - ❑ Other: _____
    _____

NECK/ARM PAIN (If applicable):

What **makes** your **pain worse**?

NECK		ARM
❑	Flexing/looking down	□
❑	Extending/looking up	□
❑	Rotating head	□
❑	Coughing/sneezing	□
❑	Other: _____	□

What makes your **NECK pain better**?

- ❑ Heat
- ❑ Cold
- ❑ Laying down
- ❑ Medication: _____
- ❑ Other: _____

What makes your **ARM pain better**?

- ❑ Placing over head
- ❑ Shaking arm
- ❑ Flexing neck/looking down
- ❑ Extending neck/looking up
- ❑ Medication: _____
- ❑ Other: _____

Overall, what **percentage** of your pain is in your **neck** versus your **arm**? (must total 100%)
(Example: You would circle "80% / 20%" if overall 80 of your pain was in your neck and 20% was in your arms)

Neck / Arm	
100%/ 0%	50% / 50%
90% / 10%	40% / 60%
80% / 20%	30% / 70%
70% / 30%	20% / 80%
60% / 40%	10% / 90%
0% / 100%	

BACK/LEG PAIN (If applicable):

What **makes** your **pain worse**?

BACK		LEG
❑	Sitting - Longer than:_____	□
❑	Walking - Longer than: _____	□
❑	Standing - Longer than:_____	□
❑	Other: _____	□

What makes your **BACK pain better**?

- ❑ Sitting
- ❑ Walking
- ❑ Standing
- ❑ Medication: _____
- ❑ Other: _____

What makes your **LEG pain better**?

- ❑ Sitting
- ❑ Walking
- ❑ Standing
- ❑ Medication: _____
- ❑ Other: _____

Overall, what **percentage** of your pain is in your **back versus** your **leg**? (must total 100%)
(Example: You would circle "80% / 20%" if overall 80% of your pain was in your back and 20% was in your legs)

Back / Leg	
100%/ 0%	50% / 50%
90% / 10%	40% / 60%
80% / 20%	30% / 70%
70% / 30%	20% / 80%
60% / 40%	10% / 90%
0% / 100%	

- Have you had a change in your:
  Bowel or bladder function? No Yes – Please describe: _____
  Gait/Way you walk? No Yes – Please describe: _____

- What type of **treatment** have you had for this problem? □ None

  - ❑ Physical Therapy
  - ❑ Chiropractic manipulation - How many adjustments?
  - ❑ Injections (please circle): Epidural/ Facet joint/ Nerve root: How many? _____
  - ❑ Surgery - Please describe: _____

  Which, if any, helped?_____

- What **studies** have you had done? □ None

  - ❑ X-Ray
  - ❑ CT/CAT scan
  - ❑ MRI
  - ❑ EMG/Nerve conduction test
  - ❑ Myelogram
  - ❑ Discogram
  - ❑ Other: _____

- Is there **anything else** you would like to tell us?

Do you have any **allergies** to medications, foods, etc.? _____

_____

List **any and all medications** you are currently taking (please give dose and frequency):

1.	4.	7.
2.	5.	8.
3.	6.	9.

Have you ever had **any surgery** (tonsils, appendix, hysterectomy, etc.)? When?

Are you (please circle) Right-handed Left-handed Ambidextrous?

Who do you currently **live with**? _____ In facility – which? _____

Do you **smoke**? No Yes - How many packs per day? _____

Do you **drink**? No Yes - What? _____ How many per week? _____

Do you have any of the following **medical conditions**?

□ NO □YES Diabetes: Insulin NO/YES
□ NO □YES Hypertension/High blood pressure
□ NO □YES High Cholesterol/Blocked arteries
□ NO □YES Heart problems - Heart Attack/Other: _____
□ NO □YES Lung problems - COPD/Asthma/ Other: _____
□ NO □YES Stomach problems – Reflux/GERD/Ulcers/Other: _____
□ NO □YES Stroke/CVA : _____Residual deficit?_____
□ NO □YES Epilepsy/Seizure disorder - When was last seizure? _____
□ NO □YES Fibromyalgia Who is treating this? _____
□ NO □YES Arthritis - Where? _____
□ NO □YES Kidney problems – Please describe:_____
□ NO □YES Liver problems – Hepatitis/Cirrhosis/Other:_____
□ NO □YES Migraines or Headaches
□ NO □YES Psychiatric issues – Please describe: _____
□ NO □YES Neurological disorders – Please describe:_____
□ NO □YES Depression
□ NO □YES Anxiety
□ NO □YES Thyroid problems – Please describe: _____
□ NO □YES Cancer – Where? _____
□ NO □YES Bleeding disorder – Please describe: _____
□ NO □YES Tuberculosis/TB
□ NO □YES HIV/AIDS
□ NO □YES Other: _____

Review of Systems: Do you **have** or have you **ever had** problems in any of the following areas:

Constitutional (wt. loss or gain, fever, malaise, etc.) □ NO □YES – explain: _____
Eyes (contacts, blindness, glaucoma, etc.) □ NO □YES – explain: _____
Ears, nose, mouth, throat (hearing loss, dentures, etc.) □ NO □YES – explain: _____
Cardiovascular (heart, circulation, chest pain, etc.) □ NO □YES – explain: _____
Respiratory (lungs, cough, breathing, etc.) □ NO □YES – explain: _____
GI (gastrointestinal, stomach, intestines, etc.) □ NO □YES – explain: _____
GU (genitourinary, bladder, genitalia, impotence, etc) □ NO □YES – explain: _____
Musculoskeletal (muscles, joints, bones) □ NO □YES – explain: _____
Integumentry (skin, breast, hair, etc) □ NO □YES – explain: _____
Neurological: □ NO □YES – explain: _____
Psychiatric: □ NO □YES – explain: _____
Endocrine (pancreatitis, glandular problems, etc.) □ NO □YES – explain: _____
Hematological/Lymphatic (blood, bleeding, lymphoma, etc.) □ NO □YES – explain: _____
Immunological (infections, etc.) □ NO □YES – explain: _____

□ All others negative What is your **Height**? _____ What is your **Weight**? _____

OFFICE USE Reviewed by: _____ **M.D.** Date: _____