

HISTORY

Please complete the following questions:

NAME: _____ Date of Birth _____ AGE _____ DATE _____

Chief Complaint

1. What is the main symptom (pain, numbness, weakness, etc.) that brings you in to see the doctor, and where is that symptom located?

2. Does that symptom radiate to any other body part? If yes, please specifically indicate where...

History of Present Illness

3. Is the symptom (circle): constant or intermittent?
(comes & goes)

4. How would you describe your pain (sharp, dull, achy, burning, throbbing, cramping, etc.)?

5. Please rate the severity of your pain (Circle)
(1=mild, 10=worst ever in your life)

0 1 2 3 4 5 6 7 8 9 10

6. How long have you had this symptom (date of onset)?

7. Do you feel any weakness? If yes, please indicate specifically where you feel weak and how you have noticed the weakness (dropping objects, legs giving out, foot drop, etc.)...

8. Do you have any numbness/tingling? If yes, please indicate where it is located...

9. Do you have any bowel/bladder problems? If yes, please describe...

10. What makes the symptom worse?

___ Sitting ___ Cough/Sneeze
___ Walking ___ Lifting
___ Standing ___ Weather
___ Lying Down ___ Range of Motion
___ Squatting Other:

11. What makes the symptom better?

___ Rest ___ Medications
___ Heat/Ice ___ Position change
___ Lying Down/Reclining Other:

12. Does the symptom disturb your sleep?

Yes No

13. Have you ever had this symptom before?

If yes, when...

Work History

14. Are you currently working? Yes No

If not, when was the date last worked...

15. Briefly describe your work, indicate if you are on any work restrictions...

Injury/Accident History

16. Is your symptom from an injury? Yes No

If yes, was the injury (circle):
work related, a motor vehicle accident, or other

17. Please describe the injury, along with the date of the injury:

18. Is there a history of an injury in the past?

If so, please describe the injury and give date...

Conservative Care

19. What treatments have you had: (Please check all that apply)

___ Physical or Aquatic Therapy
___ Chiropractic Treatments
___ Massage Therapy
___ Application of Heat/Cold
___ Acupuncture
___ TENS Unit
___ Traction (Cervical or Pelvic)
___ Neck Collar/Back Brace
___ Cortisone Injections/"Blocks"
___ Pain Clinic
___ Pain Medication (circle):
Percodan Percocet Oxycodone Ultram
Vicodin Morphine Darvocet Other:
___ Anti-Inflammatory Medications (circle):
Ibuprofen Naprosyn Bextra Vioxx
Celebrex Other:
___ Muscle Relaxants (circle):
Flexeril Soma Skelaxin Robaxin Zanaflex
___ Other medications or treatments not listed:

NAME _____

20. Surgical History:

Please list all surgeries with dates...

21. Personal Medical History (please check all that apply):

- Asthma
- Hypertension
- Heart Disease
- Diabetes
- Abdominal/Bowel Disorders
- Thyroid Disorders
- High Cholesterol
- Kidney Disease
- Stroke
- Seizures
- History of Tuberculosis
- Hepatitis or Liver Disease
- Psychiatric (depression, anxiety etc)
- Cancer (type and location):
- Transfusion Reaction
- Arthritis
- Cataracts
- Glaucoma

Other:

22. Medications You Are Currently Taking (with dosages):

23. Allergies (meds, adhesive, latex, etc.) **and reactions:**

24. Tobacco: Yes No _____ Packs per day for _____ years. Stopped smoking ____ years ago

Alcohol: Yes No

25. Height _____ Weight _____ (Office staff to complete) BP _____ Pulse _____

Patient Signature Date _____

Reviewed by: _____ Date _____

Staff Comments/Summary: _____

