

When did your problem begin? _____ (specific date of possible)

Have you seen other doctors for this condition? Yes No Describe: _____

Please describe the character of your pain, check all that apply:

- Sharp/Stabbing Sharp/Dull Achy Dull Soreness Weakness
Throbbing/Gnawing Numbness Shooting Gripping/Constricting
Burning Tingling Other _____

How bad is your pain or ache?

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable pain

How often are the complaints present?

- Constant: 76-100% Frequent: 51-75% Occasional: 26-50% Intermittent: 25% or less Night Only

When is the pain or symptom worse?

- When you wake up During the day After work In the evening After eating While sleeping

What makes the problem worse?

- Standing Sitting Lying Bending Lifting Twisting Other _____

Is there anything you can do to relieve the problem? No Yes What have you tried: _____

Since your problem began is the pain: increasing decreasing not changing

Do you sleep on your: Back Stomach Left Side Right Side

Physical activity at work: sitting more than 50% Light manual labor Heavy manual labor

General physical activity: No regular exercise program Light exercise program Strenuous exercise program

Rate your stress level: No stress Minimal stress Moderate stress Greatly stressed

Alcoholic beverages: Yes No If yes, how many drinks per week? _____

Draw on the diagram where you feel your symptoms

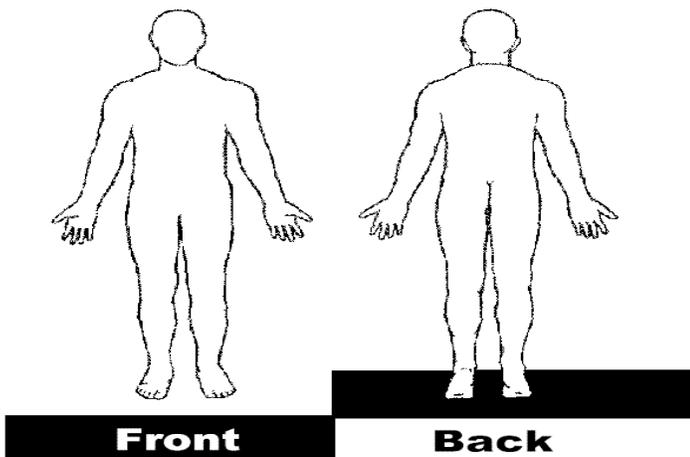
Use the letter to indicate the type and location of your pain or problem:

- A = Ache B = Burning N = Numbness
S = Sharp T = Tingling P = Pins & Needles
O = Other

Do you currently smoke? Yes No

If YES, how many packs a day: _____

Number of years: _____



Female Patients ONLY:

Are you pregnant or is there any possibility you may be pregnant? Yes No Uncertain

Date of Last Menses: _____ My Menses is: Regular Irregular

Are you currently taking an oral contraceptive (Birth Control Pill)? Yes No If yes, for how long? _____

Please include childbirth information (include dates, complications, etc): _____

Describe any falls, auto accidents or major injuries - include month & year and type of accident: _____

Describe all past surgeries: _____

List ALL medication that you are currently taking – prescription and over the counter: _____

Personal History: Please circle all that apply:

- | | | | |
|--------------------|------------------------|----------------|-------------------------|
| Aneurysm | Broken/Fractured Bones | Epilepsy | Drug Addiction |
| Osteoporosis | Eating Disorders | Alcoholism | High/Low Blood Pressure |
| Diabetes | Ulcers | Coughing Blood | Seizures/Convulsions |
| Thyroid Disease | Pace Maker | HIV Positive | Hypertension |
| Arthritis | Cancer | Stroke | Excessive Bleeding |
| Congenital Disease | Gall Bladder Issues | Ruptures | Depression |
| Tuberculosis | Asthma | Mental Illness | Heart Condition |

Family History: Please circle all that apply: Aneurysm Osteoporosis Diabetes Thyroid Disease Arthritis Cancer Stroke

Heart Condition Hypertension Asthma Other: _____

Father: Living Deceased Age is living: _____ **Mother:** Living Deceased Age is living: _____

Please check all symptoms or areas where you have problems, even if they do not seem related to your current problem:

- | | | | |
|--|--|--------------------------------------|---|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Buzzing/Ringing in Ears | <input type="checkbox"/> Lungs | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heart | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Eyes/Vision | <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach | <input type="checkbox"/> Leg Pain/Cramps |
| <input type="checkbox"/> Concentration Loss | <input type="checkbox"/> Sinus | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor Circulation |

