Name ______________________________ **Patient #**__________
(PLEASE PRINT)
Signature: ______________________________ **Date**: __________

Height _____ FT _____ IN **Weight** ______ **Employed**: Yes / No / Retired

Marital Status: Single Married Widowed

Previous Illnesses: (Check all that apply)

- ❑ AIDS, HIV, STD
- ❑ Alcoholism
- ❑ Anemia
- ❑ Aortic Aneurysm
- ❑ Asthma
- ❑ Arthritis
- ❑ Bone Fractures
- ❑ Cancer
- ❑ Chest Pain
- ❑ Diabetes
- ❑ Digestive Problems
- ❑ Emotional/Mental Difficulties
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Eye/Vision Problems
- ❑ Fainting
- ❑ Fatigue
- ❑ Fibromyalgia
- ❑ Genetic spinal conditions
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Kidney stones
- ❑ Liver trouble
- ❑ Low blood pressure
- ❑ Menstrual problems
- ❑ Multiple sclerosis
- ❑ Neurological problems
- ❑ Obesity
- ❑ Pacemaker
- ❑ Parkinson
- ❑ Polio
- ❑ Prostate problems
- ❑ Rheumatic fever
- ❑ Scoliosis
- ❑ Seizures
- ❑ Stroke/Heart Attack
- ❑ Sinus trouble
- ❑ Thyroid Disorders

Other:
____
____
____

Surgeries: (Check all that apply and circle the side if required)

- ❑ Appendectomy
- ❑ ACL Repair
- ❑ Caesarean Section
- ❑ Carpal Tunnel Decompression
- ❑ Discectomy
- ❑ Eye Surgery
- ❑ Gallbladder
- ❑ Gastrectomy
- ❑ Gynecological
- ❑ Gastric Bypass
- ❑ Hernia Repair
- ❑ Kidney Transplant
- ❑ Laminectomy
- ❑ Lumbar Decompression
- ❑ Lumbar Fusion
- ❑ Lumpectomy
- ❑ Mastectomy
- ❑ Prostatectomy
- ❑ Spinal Fusion
- ❑ Spinal Stenosis
- ❑ Tonsillectomy
- ❑ Vasectomy
- ❑ Varicose Vein Removal

Hip Replacement
RIGHT LEFT
Knee Replacement
RIGHT LEFT
Shoulder Surgery
RIGHT LEFT

Other:
____
____
____
____

Current Medications: (Check all that apply)

- ❑ Anxiety
- ❑ Allergy
- ❑ Birth Control
- ❑ Cardiovascular
- ❑ Insulin
- ❑ Muscle Relaxers
- ❑ Pain Killers
- ❑ Seizures

Other:
____
____
____

Do you have seasonal allergies: Yes / No

What, if any, medications are you allergic to: (Please list the name and the reaction)

____
____
____

Family History (Check all that apply)

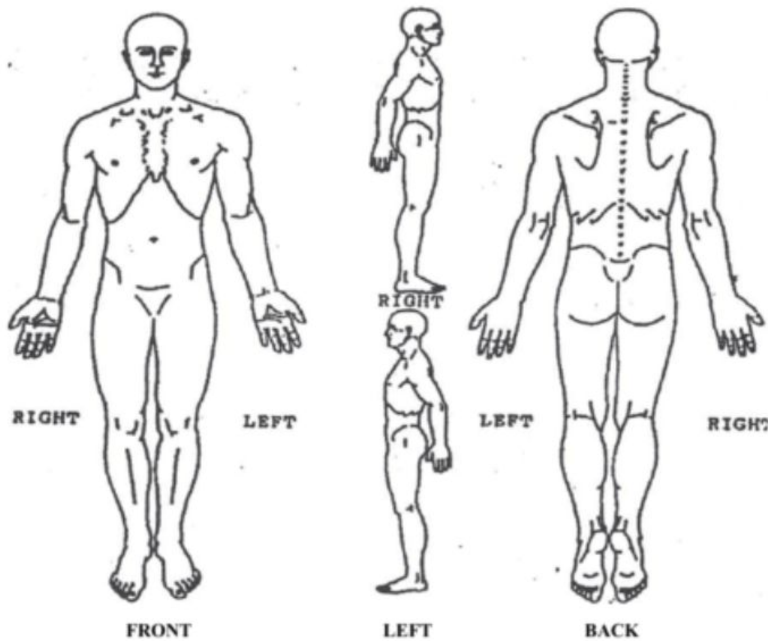
- ❏ Arthritis
- ❏ Asthma
- ❏ Back Problems
- ❏ Cancer
- ❏ Chronic Pain
- ❏ Congenital Defects
- ❏ Diabetes
- ❏ Disc Problems
- ❏ Emphysema
- ❏ Gallstones
- ❏ Headaches
- ❏ High Blood Pressure
- ❏ Migraine Headaches
- ❏ Osteoporosis
- ❏ Prostate Problems
- ❏ Scoliosis
- ❏ Seizures
- ❏ Thyroid Problems

Other:
____
____

Please circle the most accurate response:

Do you drink alcohol?	Never	Occasionally	Frequently	Daily
Do you drink caffeine?	Never	Occasionally	Frequently	Daily
Do you use tobacco?	Never	Former smoker	Some days	Daily
Do you do substance abuse?	Never	Occasionally	Frequently	Daily
Do you exercise?	Never	Occasionally	Frequently	Daily

Please indicate where you are experiencing the pain:



NECK

Location: (Check all that apply)

- ❏ Left Shoulder
- ❏ Left Arm
- ❏ Left Hand
- ❏ Left Elbow
- ❏ Left Forearm
- ❏ Right Shoulder
- ❏ Right Arm
- ❏ Right Hand
- ❏ Right Elbow
- ❏ Right Forearm
- ❏ Jaw

Symptoms: (Check all that apply)

- ❏ Aching
- ❏ Burning
- ❏ Cramping
- ❏ Diffuse
- ❏ Dull
- ❏ Excruciating
- ❏ Numbness
- ❏ Radiating
- ❏ Sharp
- ❏ Shooting
- ❏ Stabbing
- ❏ Stiffness
- ❏ Throbbing
- ❏ Tightness
- ❏ TIngling
- ❏ Weakness

Severity: Please circle the severity of the pain: **0 1 2 3 4 5 6 7 8 9 10**

Mechanism of Problem: Gradual Insidious Sudden Traumatic

How did this problem begin? (Check one below)

- ❏ Auto Accident
- ❏ Bending
- ❏ Cumulative Trauma
- ❏ Etiology Unknown
- ❏ Excessive Standing
- ❏ Excessive Walking
- ❏ Lifting
- ❏ Overexertion
- ❏ Prolonged Driving
- ❏ Prolonged Sitting
- ❏ Repetitive Motion
- ❏ Slip or Fall
- ❏ Sports Injury
- ❏ Traumatic Injury

How often is the symptom experienced? Infrequently Occasionally Intermittently Frequently

Pain Relieved By: (Check all that apply)

- ❏ Activity
- ❏ Elevation
- ❏ Exercising
- ❏ Heat
- ❏ Ice
- ❏ Immobilization
- ❏ Lying Down
- ❏ Massage
- ❏ Movement
- ❏ Pain Medication
- ❏ Resting
- ❏ Sitting
- ❏ Standing
- ❏ Stretching
- ❏ Walking
- ❏

Pain Aggravated By: (Check all that apply)

- ❏ Bending
- ❏ Coughing
- ❏ Driving
- ❏ Kneeling
- ❏ Lifting
- ❏ Looking Down
- ❏ Looking Up
- ❏ Lying Down
- ❏ Movement
- ❏ Pulling
- ❏ Pushing
- ❏ Sitting
- ❏ Sneezing
- ❏ Standing
- ❏ Weight Bearing

Associated Symptom Locations: Arm Head Shoulder

Associated Symptoms: (Check all that apply)

- ❏ Numbness
- ❏ Pain
- ❏ Soreness
- ❏ Stiffness
- ❏ Swelling
- ❏ Tingling
- ❏ Weakness

Prior Treatment: (Select NOTHING or check all that apply)

- ❏ Nothing
- ❏ Bed Rest
- ❏ Chiropractic
- ❏ Exercize
- ❏ Heat
- ❏ Hot Showers
- ❏ Ice
- ❏ Massage
- ❏ Pain Medication
- ❏ Topical Ointment
- ❏ Traction

Prior Treatment Effectiveness: With Some Relief With No Relief With Temporary Relief

UPPER / MIDDLE BACK

Location: (Check all that apply)

- ❏ Left Shoulder
- ❏ Right Shoulder
- ❏ Ribs
- ❏ Chest

Symptoms: (Check all that apply)

- ❏ Aching
- ❏ Burning
- ❏ Dull
- ❏ Excruciating
- ❏ Pulsating
- ❏ Radiating
- ❏ Sharp
- ❏ Shooting
- ❏ Stabbing
- ❏ Stiffness
- ❏ Tightness
- ❏ TIngling

Severity: Please circle the severity of the pain: **0 1 2 3 4 5 6 7 8 9 10**

Mechanism of Problem: Gradual Insidious Sudden Traumatic

How did this problem begin? (Check one below)

- ❏ Auto Accident
- ❏ Bending
- ❏ Cumulative Trauma
- ❏ Etiology Unknown
- ❏ Excessive Standing
- ❏ Excessive Walking
- ❏ Lifting
- ❏ Overexertion
- ❏ Prolonged Driving
- ❏ Prolonged Sitting
- ❏ Repetitive Motion
- ❏ Slip or Fall
- ❏ Sports Injury
- ❏ Traumatic Injury

How often is the symptom experienced? Infrequently Occasionally Intermittently Frequently

Pain Relieved By: (Check all that apply)

- ❏ Activity
- ❏ Elevation
- ❏ Exercising
- ❏ Heat
- ❏ Ice
- ❏ Immobilization
- ❏ Lying Down
- ❏ Massage
- ❏ Movement
- ❏ Pain Medication
- ❏ Resting
- ❏ Sitting
- ❏ Standing
- ❏ Stretching
- ❏ Walking
- ❏

Pain Aggravated By: (Check all that apply)

- ❏ Bending
- ❏ Coughing
- ❏ Driving
- ❏ Kneeling
- ❏ Lifting
- ❏ Looking Down
- ❏ Looking Up
- ❏ Lying Down
- ❏ Movement
- ❏ Pulling
- ❏ Pushing
- ❏ Sitting
- ❏ Sneezing
- ❏ Standing
- ❏ Weight Bearing

Associated Symptom Locations: Arm Shoulder

Associated Symptoms: (Check all that apply)

- ❏ Numbness
- ❏ Pain
- ❏ Soreness
- ❏ Stiffness
- ❏ Swelling
- ❏ Tingling
- ❏ Weakness

Prior Treatment: (Select NOTHING or check all that apply)

- ❏ Nothing
- ❏ Bed Rest
- ❏ Chiropractic
- ❏ Exercize
- ❏ Heat
- ❏ Hot Showers
- ❏ Ice
- ❏ Massage
- ❏ Pain Medication
- ❏ Topical Ointment
- ❏ Traction

Prior Treatment Effectiveness: With Some Relief With No Relief With Temporary Relief

LOWER BACK / HIP

Location: (Check all that apply)

- ❏ Left Ankle
- ❏ Left Buttock
- ❏ Left Foot
- ❏ Left Hip
- ❏ Left Knee
- ❏ Left Leg
- ❏ Left Thigh
- ❏ Right Ankle
- ❏ Right Buttock
- ❏ Right Foot
- ❏ Right Hip
- ❏ Right Knee
- ❏ Right Leg
- ❏ Right Thigh

Symptoms: (Check all that apply)

- ❏ Aching
- ❏ Burning
- ❏ Cramping
- ❏ Diffuse
- ❏ Dull
- ❏ Excruciating
- ❏ Numbness
- ❏ Radiating
- ❏ Sharp
- ❏ Shooting
- ❏ Stabbing
- ❏ Stiffness
- ❏ Throbbing
- ❏ Tightness
- ❏ TIngling
- ❏ Weakness

Severity: Please circle the severity of the pain: **0 1 2 3 4 5 6 7 8 9 10**

Mechanism of Problem: Gradual Insidious Sudden Traumatic

How did this problem begin? (Check one below)

- ❏ Auto Accident
- ❏ Bending
- ❏ Etiology Unknown
- ❏ Excessive Standing
- ❏ Excessive Walking
- ❏ Lifting
- ❏ Overexertion
- ❏ Prolonged Driving
- ❏ Repetitive Motion
- ❏ Slip or Fall
- ❏ Sports Injury

How often is the symptom experienced? Infrequently Occasionally Intermittently Frequently

Pain Relieved By: (Check all that apply)

- ❏ Activity
- ❏ Elevation
- ❏ Exercising
- ❏ Heat
- ❏ Ice
- ❏ Immobilization
- ❏ Lying Down
- ❏ Massage
- ❏ Movement
- ❏ Pain Medication
- ❏ Resting
- ❏ Sitting
- ❏ Standing
- ❏ Stretching
- ❏ Walking
- ❏

Pain Aggravated By: (Check all that apply)

- ❏ Bending
- ❏ Coughing
- ❏ Driving
- ❏ Kneeling
- ❏ Lifting
- ❏ Looking Down
- ❏ Looking Up
- ❏ Lying Down
- ❏ Movement
- ❏ Pulling
- ❏ Pushing
- ❏ Sitting
- ❏ Sneezing
- ❏ Standing
- ❏ Weight Bearing

Associated Symptom Locations: Leg

Associated Symptoms: (Check all that apply)

- ❏ Numbness
- ❏ Pain
- ❏ Soreness
- ❏ Stiffness
- ❏ Swelling
- ❏ Tingling
- ❏ Weakness

Prior Treatment: (Select NOTHING or check all that apply)

- ❏ Nothing
- ❏ Bed Rest
- ❏ Chiropractic
- ❏ Exercize
- ❏ Heat
- ❏ Hot Showers
- ❏ Ice
- ❏ Massage
- ❏ Pain Medication
- ❏ Topical Ointment
- ❏ Traction

Prior Treatment Effectiveness: With Some Relief With No Relief With Temporary Relief