

Welcome

Personal Information

Name: _____ Today's Date: _____
Last First Mi Mr Mrs Ms Dr

Home Address: _____
Street City State Zip

Telephone: (____) _____ Social Security #: _____ Driver's License #: _____

Age: _____ Birthdate: ____/____/____ Sex: Male Female Status: Married Single Widowed Divorced Number of Children: _____

Occupation: _____ Employer: _____ Wk#: (____) _____ Years Employed: _____

Spouse Name: _____ Occupation: _____ Employer: _____ Social Security #: _____

Person Responsible for this account: _____ Health Plan: _____

Subscriber's Name: _____ ID#: _____ Group#: _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider understand your health condition.

Please describe your problem and how it began. Date problem began: ____/____/____

How bad is your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present? Describe your current pain/symptoms:

- | | | | |
|---|---|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Intermittently | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Frequently | <input type="checkbox"/> Constantly |
| <input type="checkbox"/> Sharp/Stabbing | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Aches | |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Soreness | <input type="checkbox"/> Weakness | |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Shooting | <input type="checkbox"/> Gripping | |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Improving | <input type="checkbox"/> Getting Worse | <input type="checkbox"/> No Change | |
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Walking | |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Sitting | <input type="checkbox"/> Movement | |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Inactivity/Rest | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Walking | |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Sitting | <input type="checkbox"/> Movement | |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Inactivity/Rest | <input type="checkbox"/> Other _____ | |
| Can you perform your daily home activities? | <input type="checkbox"/> Yes, only with help | <input type="checkbox"/> Not at all | |
| Do you exercise? | <input type="checkbox"/> Yes, only occasionally | <input type="checkbox"/> Not at all | |
| Describe your job requirements: | <input type="checkbox"/> Light Labor | <input type="checkbox"/> Heavy Labor | |
| Can you perform your daily work activities? | <input type="checkbox"/> Only some | <input type="checkbox"/> Not at all | |
| Describe your stress level: | <input type="checkbox"/> Moderate | <input type="checkbox"/> High | |

Since it began, is your problem: What makes the problem better?

What makes the problem worse?

Can you perform your daily home activities? Do you exercise?

Describe your job requirements: Can you perform your daily work activities?

Describe your stress level: What treatment(s) have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic) _____

Have you had X-rays, MRI or other tests for this condition? What tests and when? _____

Please mark area(s) of injury or discomfort as shown below in the example. Include degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

Example

Numbness **N**

Pins & Needles **P**

Burning **B**

Aching **A**

Stabbing **S**

Example

Right Side

Front Side

Back Side

Left Side

Present Weight _____ pounds Height _____ feet _____ inches

Current Medications _____

Do you have a permanent disability rating? Yes No

Hospitalizations/Surgical Procedures _____

Location _____

Date rating received ____/____/____

Rating percentage _____ %

Medical History

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently troubled by a particular symptom, check that symptom in the present column. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

- | Past | Present | Condition |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder pain (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in upper arm or elbow (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand pain (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist pain (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Lower back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in upper leg or hip (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in lower leg or knee (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in ankle or foot (R _____ L _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | General fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/eczema/rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema (chronic lung disorders) |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic sinusitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (ear noises) |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disorders (by condition) |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of bladder control |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/irregular bowel habits |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable colon |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |

- | Past | Present | Condition |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Liver/gallbladder problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular incoordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling, Stiffness of joint(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack (date) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pains |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia/Bulimia |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor, explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer, explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Coffee/tea/caffeinated soft drinks: cups/cans per day _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or alcohol dependence |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco, frequency _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol, frequency _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth control pills, type _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Profuse menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Number of births _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Number of pregnancies _____ |

If a family member has had any of the following, please mark the appropriate box:

- | | | | |
|--|---------------------|---|---------------------|
| <input type="checkbox"/> Cancer | Family member _____ | <input type="checkbox"/> High blood pressure | Family member _____ |
| <input type="checkbox"/> Chronic back problems | Family member _____ | <input type="checkbox"/> Lung problems | Family member _____ |
| <input type="checkbox"/> Chronic headaches | Family member _____ | <input type="checkbox"/> Lupus | Family member _____ |
| <input type="checkbox"/> Diabetes | Family member _____ | <input type="checkbox"/> Rheumatoid arthritis | Family member _____ |
| <input type="checkbox"/> Heart problems | Family member _____ | | |

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

Signature _____

Date _____