

PATIENT NAME: _____ ACCT#: _____ DATE _____

1. Describe your current complaint and how the problem began: _____

How long have you had this condition? _____ Date of onset: _____

2. How would you describe this pain?

- Sharp Soreness Throbbing Tingling Dull Stiffness
Spasm Burning Numbness Weakness Ache Shooting

3. How would you rate the intensity of the pain? (Circle the appropriate number)

- 0 1 2 3 4 5 6 7 8 9 10
(no pain) (moderate pain) (terrible/unbearable pain)

4. How often is your pain?

- Constant (81-100%) Frequent (51-80%) Occasional (26-50%) Intermittent (25% or less)

5. Since your problem began is the pain?

- Getting worse Getting better Staying the same

6. How did your problem begin?

- Auto accident Work related Other accident Gradual Sudden Other _____

7. What makes the problem better?

- Nothing Walking Standing Sitting Moving around/exercise Lying down Inactivity

8. What makes the problem worse?

- Nothing Walking Standing Sitting Moving around/exercise Lying down Inactivity

9. Are you taking any medications?

- Yes No Describe: _____

10. Were you previously treated for an earlier occurrence of this condition? Yes No

11. What is your physical activity at work?

- Mostly sitting Light manual labor Moderate manual labor Heavy manual labor

12. Do you exercise?

- None 1-2x a wk 3-4x a wk Daily Cardiovascular Weights Sports _____

13. What is your general stress level?

- None Minimal stress Moderate stress Greatly stressed

14. Is your problem affecting your ability to work or do daily activities? Yes No

If yes, explain. _____

Mark All That Apply:

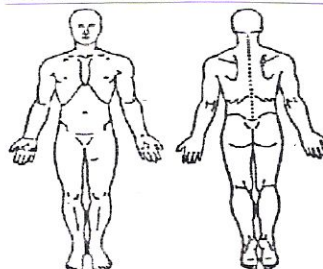
Symptom	Past	Present	Symptom	Past	Present	Symptom	Past	Present
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Headache/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Elbow Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Wrist/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Hip or Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Foot/Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Stiff Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Weight gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Surgeries/Hospitalizations: _____

Previous Illnesses: _____

Previous Traumas: _____

PLEASE MARK AN X ON THE PICTURE OF THE AREAS OF COMPLAINT OR SYMPTOMS



Patient/Guardian Signature _____ Date _____