

NAME: _____

DATE: _____

Age: _____ Gender: Male Female Hand Dominance: Right Left

Who referred you for evaluation? _____

Who is your primary doctor? _____ Address: _____

What is being examined today? _____ Which side? (Right/Left) _____

DATE of accident, or How long have you had illness / problem / symptoms? _____

Please describe your injury: _____

SYMPTOMS:

Where is your pain? How long has it been there?

<u>Location</u>	<u>Duration (wks / yrs)</u>
<input type="checkbox"/> Head	_____
<input type="checkbox"/> Neck	_____
<input type="checkbox"/> Shoulder L / R	_____
<input type="checkbox"/> Arm L / R	_____
<input type="checkbox"/> Hand L / R	_____
<input type="checkbox"/> Mid Back	_____
<input type="checkbox"/> Low Back	_____
<input type="checkbox"/> Buttocks L / R	_____
<input type="checkbox"/> Hip L / R	_____
<input type="checkbox"/> Leg L / R	_____
<input type="checkbox"/> Foot L / R	_____

When having pain is it generally...

- Mild discomfort
- Dull, achy pain
- Hard, aching pain, frequently worse
- Severe pain, sharp/shooting at times
- Burning pain
- Very severe, sharp, stabbing
- Extremely disabling

How often are you having pain?

- Rarely, if ever
- Occasional (If so, how often? _____)
- Recurrent (few days every month)
- Frequent (more than half the time)
- Very frequent (nearly every day)
- Constantly

How much of your pain is in your neck/back and how much is in your arm/leg? (must total 100%)

_____ % neck/back + _____ % arm/leg = 100%

Rate your pain at its worst and at its best:
(0 = No pain, 10 = Worst imaginable pain)

0 1 2 3 4 5 6 7 8 9 10 at is worst

2 3 4 5 6 7 8 9 10 at is best

Have you experienced any of the following:

- Numbness / Tingling in arms; (L), (R)
- Numbness / Tingling in hands; (L), (R)
- Numbness / Tingling in legs; (L), (R)
- Numbness / Tingling in feet; (L), (R)
- Weakness in legs; (L), (R)
- Weakness in arms; (L), (R)
- Clumsiness of hands; (L), (R), (both)
- Balance problems
- Bladder problems: _____
- Bowel problems: _____
- Pain that wakes you from sleep (night pain)

What makes your pain better?

- Lying down
- Sitting
- Standing
- Walking
- Lifting
- Sleeping
- Ice
- Other (please describe): _____
- Looking up/down
- Looking L / R
- Bending Forward
- Bending Backwards
- Sneeze / Cough
- Twisting
- Heat

What makes your pain worse?

- Lying down
- Sitting
- Standing
- Walking
- Lifting
- Sleeping
- Ice
- Other (please describe): _____
- Looking up/down
- Looking L / R
- Bending Forward
- Bending Backwards
- Sneeze / Cough
- Twisting
- Heat

What time of day is your pain usually worst?

- Morning
- Mid-day
- Evening
- Same all day
- At night

Describe the course of your condition as:

- Rapidly worse
- Slowly worse
- Unchanged
- Rapidly better
- Slowly better

What treatment have you received?

- None
- Physical Therapy
- Chiropractic
- Traction
- Acupuncture
- Anti-inflammatory med
- Muscle relaxants
- Narcotic medications
- Epidural injections
- Other: _____

What studies have been done on your spine?

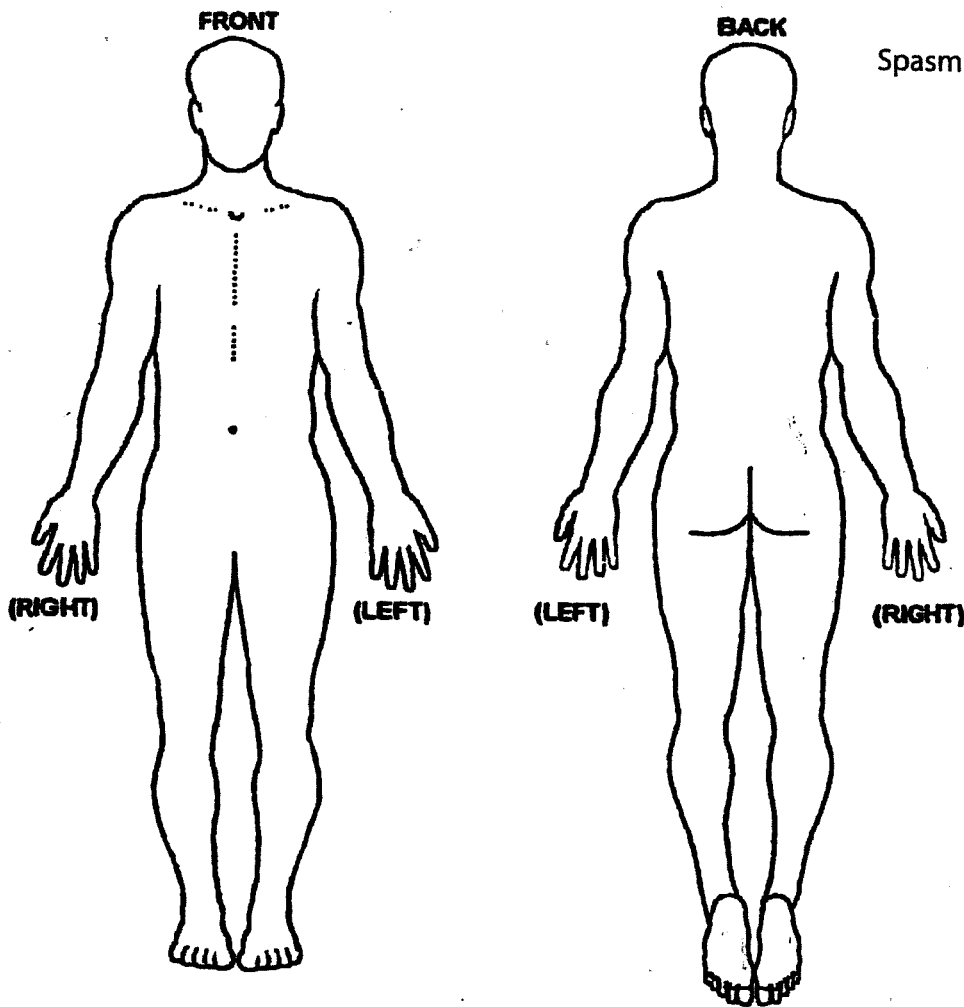
- None
- MRI
- Myelogram
- DEXA Scan
- X-rays
- CT scan
- Bone Scan
- EMG

Have you had previous spinal surgery? No Yes Did it help you? No Yes
 If yes, what type of surgery, who was the surgeon and when was it done? _____

PAIN DRAWING:

Indicate where you are having symptoms by using the proper **symbols** and **arrows** to show where the pain goes or shoots. Be sure to show **ALL areas involved** and to indicate where the **PAIN IS WORST**.

- Aching / Pain (XXX)
- Numbness / Tingling (000)
- Pins / Needle (: : : : :)
- Burning (////)
- Spasm / Cramp (ΔΔΔ)



Please indicate that you have completed this form truthfully and as accurately as possible by signing below:

Signature **Date**

Review of Systems:

Please check and describe any signs or symptoms which you are currently experiencing from any of the following organ systems. If none, please write "NONE".

Please list any other problems you may be experiencing that you do not see listed.

Constitutional Symptoms:

- Fever Chills Night Sweats Weight Loss Fatigue Appetite loss

Eyes:

- Corrective lenses Cataracts Blurry Vision Double Vision

Ears, Nose, Mouth, Throat:

- Hearing loss Sinus Congestion Hoarse voice Painful/Difficulty swallowing

Cardiovascular (Heart, circulation):

- Chest pain Cool extremities (poor circulation) Cold sensitivity

Respiratory (Lungs):

- Shortness of breath Painful breathing Wheezing Cancer

Genitourinary (i.e. urinary tract infection, prostate):

- Urinary frequency Urinary incontinence Painful urination
 Sexual dysfunction Enlarged prostate Cancer

Gastrointestinal:

- Reflux Ulcers Cancer
 Diarrhea Constipation Bloody stool
 Nausea Vomiting

Musculoskeletal:

- Joint pain, where? _____
 Joint swelling
 Joint stiffness Fibromyalgia

Skin/Breast:

- Cancer, where? _____ what type? _____
 Lumps or masses, where? _____
 Rashes

Psychiatric:

- Depression Manic
 Eating Disorder

Neurological:

- Stroke Trouble speaking Peripheral nerve disorder, list? _____
 Balance problems Seizures Tremor Reflex Sympathetic Dystrophy

Endocrine:

- Diabetes Hypoglycemia Thyroid
 Parathyroid Adrenal Osteoporosis

Hematologic/Lymphatic:

- Anemia Clotting disorder
 Platelet disorder Sickle Cell
 Lymphedema

Immunologic:

- Rheumatoid Lupus

- Swollen lymph nodes, where? _____
 Tender lymph nodes, where? _____

Doctor's Signature (documenting review of above)

Financial Interest Consent

I, _____ (patient), acknowledge and accept that my physician may have a financial interest in hospitals, surgery centers, imaging centers, physical therapy and/or surgical devices that he/she chooses to utilize. I hereby recognize my right to choose another physician or request the services of another facility or device be used.

SIGNATURE

DATE