Name: _____ Age: _____ Date: _____
Accompanied by_____ Relationship_____
E-mail: _____@_____

MEDICAL BACKGROUND INFORMATION

Please name the professionals that you have seen for this condition:

Name	Specialty	Town	Phone

Who is your primary care doctor and which other physicians have you seen in the past 12 months?

Name	Specialty	Town	Phone

Which pharmacy do you use? If more than one, please list them all.

Name	Address	Phone #

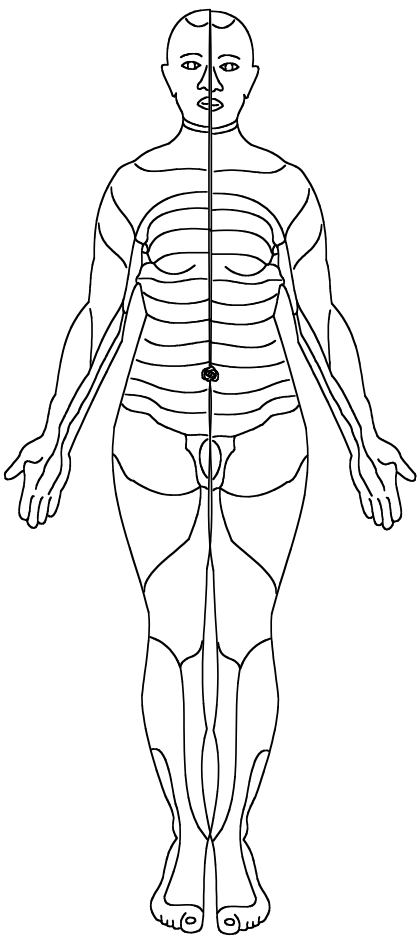
FOR OFFICE USE: Patient ID confirmed:
□ D.O.B □ Phone #

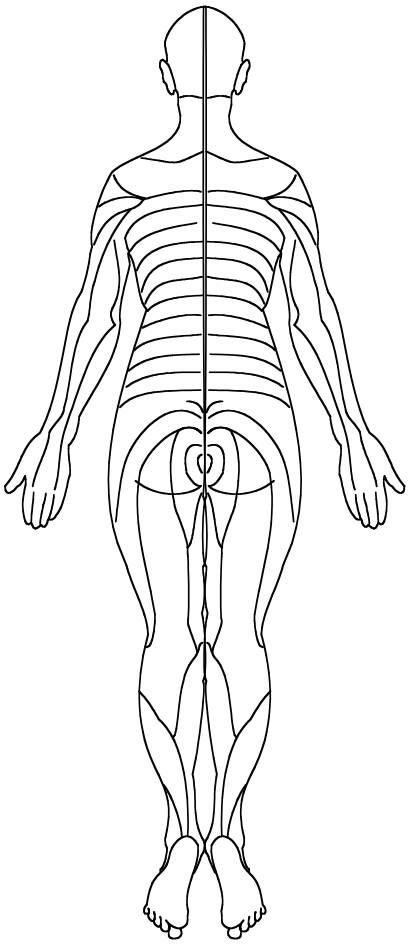
Patient Signature_____Date_____

PAIN LOCATION DRAWINGS

Please indicate the primary location of your pain on the drawing below:

R Front L **L Back R**





When did your pain begin:_____

Please describe as precisely as possible how your pain began:
*car accident work injury cancer surgery other by itself*_____
_____
_____

Please describe if or how your pain has changed since then:
*the same worsening improving*_____
_____

Please circle what your pain feels like (more than one choice possible):
aching stabbing sharp dull burning tingling deep superficial

Approximately, how often do you have pain flare-ups? _____

Approximately, how long does a painful episode last? _____

What makes your pain better? _____

What makes your pain worse? _____

How far can you walk without stopping? _____

Do you use a cane or walker? Yes / No

Do you need help getting dressed? Yes / No

Is your back painful and stiff in the morning? Yes / No

Is sitting painful? Yes / No

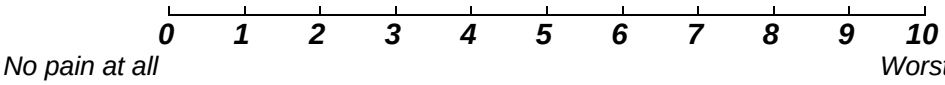
Is coughing or sneezing painful? Yes / No

Do you have a lawsuit pending? Yes / No

PAIN SEVERITY SCALE

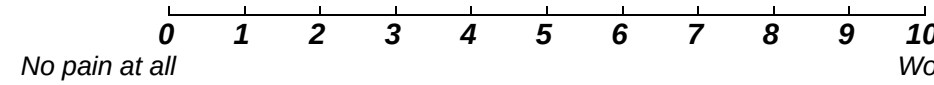
Please mark the severity of your pain on the pain scales:

At its worst:



No pain at all *Worst pain imaginable*

At its least:



No pain at all *Worst pain imaginable*

PREVIOUS TESTS

Please list (as well as you can remember) tests such as MRI, CT, EMG, X-Ray, Scans, Discograms, and others that you underwent for this condition:

Test	Date	Result

PREVIOUS TREATMENTS

Have you received any of the following treatments for this condition, and was this treatment beneficial to you?

treatment	***beneficial effect***	***duration or how many/Provider***
Acupuncture	good limited worse N/A	_____
Chiropractic	good limited worse N/A	_____
Physical therapy	good limited worse N/A	_____
TENS treatment	good limited worse N/A	_____
Massage	good limited worse N/A	_____
Trigger point	good limited worse N/A	_____
Epidural	good limited worse N/A	_____
Facet joint	good limited worse N/A	_____

_____

Please name medications that you have tried and that were **not** effective:

_____
_____
_____
_____

MEDICAL HISTORY

Please list **all medications** that you are currently taking, prescription and over the counter.

Medication Name	Physician Name	Dose

Please name medications or foods which cause side effects or allergic reactions.

Medication Name	The kind of side effect/allergic reaction

What surgeries have you had in the past?

Procedure	Date	Surgeon

Ever had side effect to anesthesia? Yes / No

Ever faint or pass out with blood work or IV's? Yes / No

GENERAL MEDICAL CONDITION

Please circle if you have any of the following symptoms or conditions.

cancer, weight loss, weight gain, fevers, hiccups longer than a day.

rashes, bruising, nose bleeds, bleeding disorder, low platelets

seizures, strokes, glaucoma, hard of hearing, retinopathy, blurred vision.

productive cough, wheezing, emphysema, asthma, sinus trouble, shortness of breath, tuberculosis, sleep apnea.

chest pain, angina, heart attack, heart murmur, extra heart beats, atrial fibrillation, rheumatic heart fever, high blood pressure, cardiac stents.

reflux, heartburn, hiatal hernia, ulcer, hepatitis, liver disease or jaundice, colitis.

difficulty with urination, incontinence, kidney stones.

thyroid disease, high blood sugar or diabetes, high cholesterol, osteoporosis, osteopenia.

If you are a diabetic, what is your blood sugar in the morning? _____, and, What is your Hemoglobin A1C level? _____ When was it last drawn? _____(it would be helpful if you bring a copy of your recent blood work to your first visit)

Please name any other medical conditions that you have or have had in the past:

_____
_____

For women:

Is there any possibility that you may be pregnant? Yes No
How many pregnancies? _____ How many live births have you had? _____

LIFESTYLE ACTIVITIES

Please describe your usual employment including physical requirements:
_____
_____

If you are not currently working because of pain, when did you stop:_____
Employers name and address: _____
_____

Are you a veteran of any military conflict? Yes / No
Were you ever exposed to any known environmental hazards? Yes / No
How do you live: (*Single) (Married) (Divorced) (Parents) (Partner) (Health Facility)*

If you use alcohol, how much:_____
Was alcohol a problem for you in the past? Yes No
Is there a history of substance abuse? Yes No
If you smoke, how many packs a day?_____
If you smoked in the past when did you stop?_____

How many hours do you usually sleep each night?_____
How many times do you wake up?_____

Do you have any of the following feelings?
Hopelessness helplessness crying spells anger frustration depression

Is there a history in your family of any of the following conditions?
heart disease, cancer, depression, diabetes, arthritis, low back pain, osteoporosis.

Emergency Contact:_____
Have you seen your Primary Care Physician for a physical within a year? Yes No

PREVENTATIVE MEDICAL SCREENING TESTS

Test	Normal	Abnormal	N/A	Date
Mammogram				
PAP smear				
Prostate exam				
PSA				
Colonoscopy				
Cardiac Stress Test				
Bone Density				