



Name: _____ Age: _____ Date: _____ Ticket# _____

Responsible Party: _____ Referred by: _____

CHIEF COMPLAINT:

What is the reason for your visit? _____

HISTORY OF PRESENT PROBLEM:

When did this problem start? _____ Work Injury Auto Accident Other _____

Is your pain? constant intermittent other _____

Describe your pain: (check all that apply): dull throbbing aching sharp stabbing burning
 tingling cramping deep superficial other _____

Indicate if pain is: **(I)ncreased (D)ecreased (N)o Change**

Sitting _____ Standing _____ Walking _____ Lying _____ Bending _____ Coughing/Sneezing _____

Bowel movements _____ Weather Changes _____ Other _____

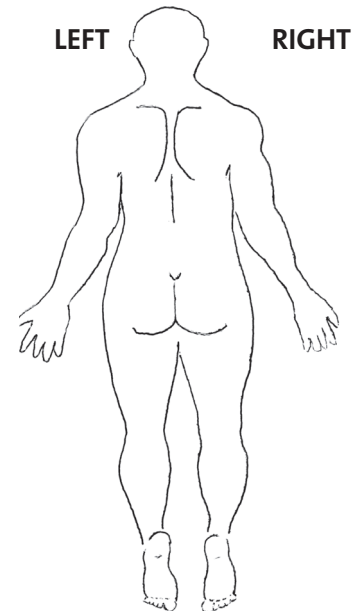
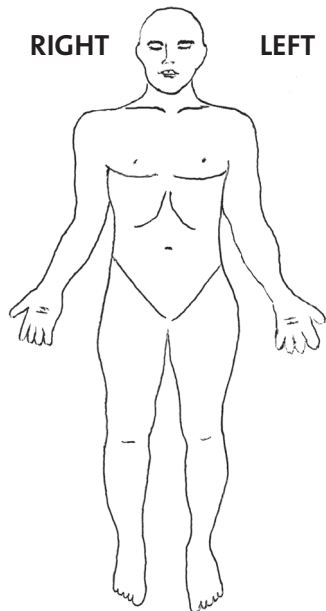
What does your pain limit: work sleep daily activities recreational activities no limit

Have you ever had these or similar symptoms in the past? Yes No If yes, when? _____

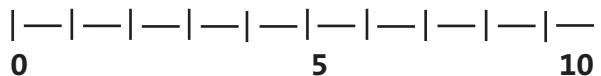
Past Treatments (Include PT, nerve blocks, epidurals, trigger point injections, surgery, and medications for this condition)

Diagnostic tests: _____

Please use the diagram below to indicate the area of the most significant pain.
Shade in the areas of your pain: If more than one location please rank 1,2,3, etc.



Please indicate your current level of pain:
(0 = No Pain and 10 = Unbearable Pain)



How long can you stand? _____ no limit How far can you walk? _____ no limit

Since the onset of the problem, has it improved? Yes No How much: _____%

Since the onset of the problem, have you developed loss of bowel or bladder control? Yes No

Do you have any weakness? Yes No If so, describe: _____

Work status: Regular duty Light duty Off from work because of this problem. Dates off: _____

Are you involved in or considering any legal activity concerning your pain? Yes No
If so, who is your attorney? _____

Are you presently taking: Coumadin Plavix Aspirin Anti-inflammatory drugs Other blood thinner

Current Medications: (include over-the-counter medications): _____

ALLERGIES: _____

PAST MEDICAL HISTORY: (none)

- | | | | | |
|--------------------------------------|--|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> depression | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> heart disease | <input type="checkbox"/> heart attack | <input type="checkbox"/> stroke | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> kidney disease | <input type="checkbox"/> seizures | <input type="checkbox"/> cancer | <input type="checkbox"/> lung disease/asthma |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> other: _____ | | | |

PAST SURGICAL HISTORY: (none)

FAMILY HISTORY: (none)

- | | | | | |
|------------------------------------|--|-----------------------------------|--|---|
| <input type="checkbox"/> headaches | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> psychiatric disorders | <input type="checkbox"/> back/neck disc disease |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> seizures | <input type="checkbox"/> cancer | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> lung disease / asthma |

SOCIAL HISTORY:

Marital Status: **S M W D** Children:

Residence: House One Story Mobile Home Apartment Steps to enter - # _____ Assisted Living/Nursing Home

Living: Alone With Spouse With Family With Friends Sitters Other

Functional Status: Independent Assistance with ADL's Ambulatory with gait aid Other

Smoker: Yes No #Packs/day _____ Have you ever consumed illegal drugs? Yes No

Do you drink beer/wine/liquor? No Yes How much? _____ How often? _____

Have you ever had problems with drug or alcohol use/dependency? Yes No

Occupation: _____

REVIEW OF SYSTEMS - PROBLEMS EXPERIENCED AT THE PRESENT TIME: Check all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> weight changes | <input type="checkbox"/> appetite changes | <input type="checkbox"/> sleep disturbance |
| <input type="checkbox"/> fever | <input type="checkbox"/> visual changes | <input type="checkbox"/> swallowing |
| <input type="checkbox"/> hoarseness | <input type="checkbox"/> headache | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> cough | <input type="checkbox"/> wheezing | <input type="checkbox"/> sinus trouble |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> constipation | <input type="checkbox"/> urinary frequency |
| <input type="checkbox"/> rashes | <input type="checkbox"/> myalgia (muscle pain) | <input type="checkbox"/> arthralgia (joint pain) |
| <input type="checkbox"/> heat/cold intolerance | <input type="checkbox"/> nervousness | <input type="checkbox"/> lethargy |
| <input type="checkbox"/> depression | <input type="checkbox"/> anxiety | <input type="checkbox"/> mania |
| <input type="checkbox"/> gait change | <input type="checkbox"/> weakness | <input type="checkbox"/> joint swelling |
| <input type="checkbox"/> spasms | <input type="checkbox"/> muscle cramps | <input type="checkbox"/> stiffness |
| | <input type="checkbox"/> All other systems are negative | |