Patient Information

Patients Last name: **First:** **Middle:**	**Date of Birth** / /	**Age**
Employer:(currently working: ☐Y ☐N) **Occupation**: (last day worked:___) Years at Job: Hobbies/Activities:	**Dominant Hand** ☐R ☐L	**Gender** ☐M ☐F

Injury Information

What body parts were initially injured? 1.	2.
3.	4.

Describe how the injury happened:

Date of injury: **Your symptoms began:** ☐ Unknown ☐ Immediately ☐ Gradually

What treatments have you already received for this condition?

☐Surgery:_____ Date:
☐Injection:_____ Date:
☐Physical Therapy:_____
☐Chiropractic:_____
☐Other:_____

What diagnostic test have you received for this condition? (*Please list approximate dates*) ☐ None

☐X-Ray:_____ ☐MRI:_____ ☐CT Scan:_____
☐Bone Scan:_____ ☐EMG/NCV:_____ ☐Lab Test:_____

What body parts are currently painful? 1.	2.
3.	4.

Have you ever had this problem before? ☐Yes ☐No **When**_____ **Treatment rec'd** _____

Since the injury/condition began your symptoms are: ☐Increasing ☐Decreasing ☐Not changing

How much of the day do you feel your symptoms: ☐Occasionally (10-25%) ☐Intermittent (26-50%) ☐Frequent (51-80%) ☐Constant (80-100%)

Choose below what most accurately describes your symptoms:

☐ Pain is annoying but able to perform all activities
☐ Pain is tolerant but may cause difficulty performing some activities
☐ Pain interferes with performance of all activities
☐ Pain is so severe that you are unable to perform any activities

Sleep: ☐ Good ☐Moderate ☐Difficult ☐Only with meds | Position: ☐Back ☐Side ☐Stomach

What makes your injury/conditions feel better or worse? Use "**O**" for better, "**X**" for worse

___Nothing ___Sitting ___Standing ___Walking ___Running ___Stairs
___Movement ___Exercise ___Stretching ___Medication ___Lying Down ___Kneeling
___Twisting ___Bending ___Lifting ___Writing ___Keying ___Coughing
___Rest ___Sneezing ___Repetitive Hand Motion ___Other: _____

Symptoms are worst: ☐AM ☐Mid-day ☐PM | **Symptoms are best:** ☐AM ☐Mid-day ☐PM

Medical History

Please list any prescription medications you are currently taking: (including pills, injections, &/or skin patches)

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Please list any over-the-counter medications you are currently taking:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Do you smoke? ☐Yes ☐No | **Do you have a pacemaker?** ☐Yes ☐No

FOR WOMEN: Are you currently pregnant or think you might become pregnant? ☐Yes ☐No

Have you ever been diagnosed with having any of the following?

☐ Cancer	☐ Diabetes	☐ High blood pressure
☐ Circulatory problems	☐ Asthma	☐ Emphysema/Bronchitis
☐ Thyroid problems	☐ Heart Problems	☐ Multiple Sclerosis
☐ Rheumatoid arthritis	☐ Other arthritic conditions	☐ Osteoporosis
☐ Stroke	☐ Tuberculosis	☐ Depression
☐ Kidney disease	☐ Anemia	☐ Hepatitis
☐ Chemical dependency (drugs)	☐ Epilepsy	☐ Other:_____

Have you recently noted any of the following?

☐ Weight loss/gain	☐ Nausea/vomiting	☐ Dizziness/lightheadedness
☐ Fatigue	☐ Unusual weakness	☐ Fever/chills/sweats
☐ Numbness or tingling	☐ Abdominal pain	☐ Headaches
☐ Chest Pain	☐ Vision/eye problems	☐ Hearing problems
☐ Unusual joint/muscle swelling	☐ General arm/leg swelling	☐ Excessive bleeding/easy bruising
☐ Difficulty breathing	☐ Regular/persistent cough	☐ Difficulty swallowing
☐ Problems sleeping	☐ Sexual difficulties	☐ Night sweats
☐ Heart racing in your chest	☐ Heartburn/indigestion	☐ Post menopause
☐ Constipation/diarrhea	☐ Blood in stool	☐ Blood in the urine
☐ Problems urination (difficulty)	☐ Urinary incontinence	☐ Pregnant (or think you might be)
☐ Stress at home or work	☐ Tremors	☐ Seizures
☐ Skin problems (ex: rash, redness)	☐ Neck/back pain	☐ Wheezing
☐ Pain with sweats	☐ Shortness of breath	☐ Other:_____

Please list any allergies we should know about:

Please list any surgeries or other conditions for which you have been hospitalized: (include approx. dates)

Please list any significant injuries for which you have been treated in the past: (include approx. dates)

During the past month have you been feeling down, depressed or hopeless? ☐Yes ☐No

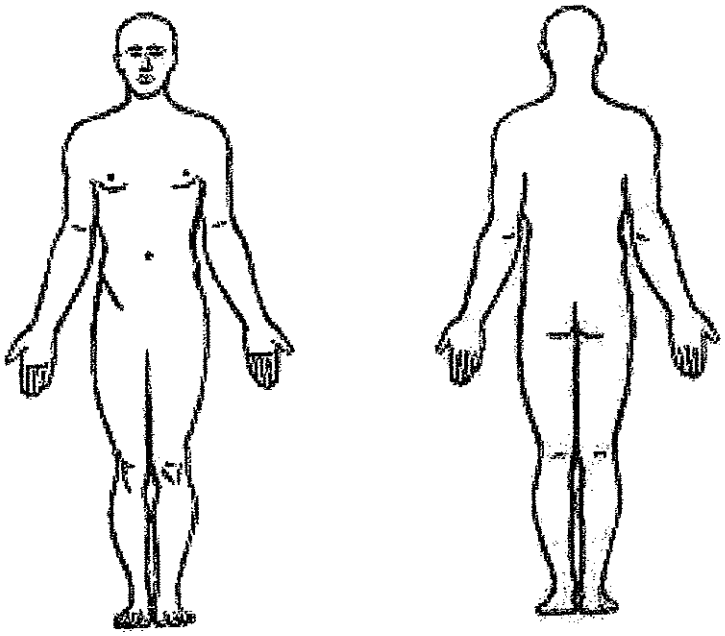
During the past month have you been often been bothered by little interest or pleasure in doing things that you enjoy? ☐Yes ☐No

Is this something with which you would like help? ☐ Yes ☐ Yes, but not today ☐ No

Body Chart:

Please mark the areas where you
Feel symptoms on the chart to the right
With the following symbols to describe
Your symptoms:

↓Shooting/sharp pain
ODull/aching pain
✚Numbness
=Tingling



I would rate my pain **CURRENTLY** as:

0 (none) 1 2 3 (annoying) 4 5 6 (uncomfortable) 7 8 (horrible) 9 10 (excruciating)

The **LEAST** pain I have had **IN THE LAST WEEK** is:

0 (none) 1 2 3 (annoying) 4 5 6 (uncomfortable) 7 8 (horrible) 9 10 (excruciating)

The **WORST** pain I have had **IN THE LAST WEEK** is:

0 (none) 1 2 3 (annoying) 4 5 6 (uncomfortable) 7 8 (horrible) 9 10 (excruciating)