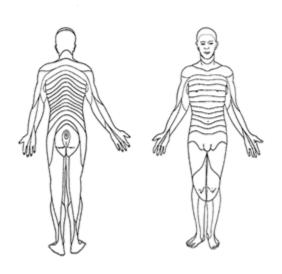
## Initial Patient History

Visit date:				Page 1
Name:		Who do you li	we with? (Please in	clude ages)
Age:				
Sex: Male / Female Left / Primary Care Physician:				
SYMPTOMS: (Please circle of Back pain Neck pain Arm pa Other:	in Leg pain	recently?	any major life char	nges Yes / No
The pain has been present for				
0-1 week 6-12 n	nonths	PRIOR IN III	RIES/TRAUMA:	
1-4 weeks 1-3 yes			rienced any major	
4-8 weeks 3+ year		your life?	major and major	Yes / No
3-6 months			xplain	
Does the pain radiate toan arm?	P Right / Left			
	Right / Left			
Do you have weakness inan arm	n? Dight / Laft	Have you had	any bodily injuries	in your life
	Right / Left	including fract		Yes / No
_				
Do you have numbness inan arm	_			
a leg?	Right / Left			
Did you have an injury?	Yes / No			
At work?	Yes / No	To your knowl	edge, did you have	e a
Motor vehicle accident?	Yes / No	traumatic birth		Yes / No
Other injury:		If yes, please e	xplain	
Date of injury:				
Any loss in your bladder or bowel				
control?	Yes / No			
Does your pain wake you up at night	t? Yes / No	TREATMEN'	T HISTORY:	
			l any of the follow	ing for your pain?)
What relieves your pain?		Medications?		Yes / No
Lying down Sitting Walking		If yes, names?		
Other:		Physical thera	npy?	Yes / No
What makes your pain worse?		<b>Injections?</b>		Yes / No
Lying down Sitting Walking			pe	
Other:		Chiropractic?	1	Yes / No
		Counseling?		Yes / No
Does your pain limit your ability to	function? Yes / No	Other? Please	e list	
If yes, please describe				
, , , , , , , , , , , , , , , , , , ,		Names of treat		
		What diagnost	ic tests have you h	ad?
Are you independent in normal dail:	y activities?	X-ray	Bone scan	Myelogram
r and a second	Yes / No	MRI	Discogram	CT scan
Has this changed recently?	Yes / No	Nerve study/E		

PAST MEDICAL HISTORY:			SOCIAL HISTORY:			
(Do you have any of the following medical problems?)						Partner
						ved
AIDS/ HIV	Yes/No Drug abuse	Yes/No	Do you smoke to	obacco?	Yes / No	)
Arthritis	Yes/No Bleeding Probs	Yes/No	If yes, a	mount	packs per day.	/ wk
Cancer	Yes/No Diabetes	Yes/No	Do you drink ald	cohol?	Yes / No	)
Asthma	Yes/No Depression	Yes/No	If yes, a	mount	beers per day/	wk
Lung disease	Yes/No Epilepsy	Yes/No	-		shots per day/	/wk
Fibromyalgia	Yes/No Gout	Yes/No	Do you use any		nal drugs? Yes / 1	
Headaches	Yes/No Heart disease	Yes/No				
Hepatitis	Yes/No High blood pres	ss Yes/No	Are you currentl	y on a sp	ecial diet? Yes /	No
Kidney problems	Yes/No Muscle disease	Yes/No		ype		
Osteoporosis	Yes/No Polio	Yes/No	Do you exercise	regularly	? Yes / No	)
Psychiatric d/o	Yes/No Stomach ulcers	Yes/No				
Chronic heartburn		Yes/No	• .	1 7		
Thyroid problems	Yes/No Alcohol abuse	Yes/No				
				iov doing	in your spare time	e?
PAST SURGICAL	I HISTODY.					
	evious surgeries with date	(s)				
					Does any membe	r of your
			family have a hi			** **
			AIDS/ HIV		Drug abuse	Yes/No
			Arthritis		Bleeding Probs	Yes/No
			Cancer		Diabetes	Yes/No
OCCUPATIONA			Asthma		Depression	Yes/No
			Lung disease		Epilepsy	Yes/No
Employer:			Fibromyalgia	Yes/No		Yes/No
	current job?month		Headaches		Heart disease	Yes/No
	wing best describes you cu		Hepatitis		High blood press	
Working full tir		time	Kidney probs		Muscle disease	Yes/No
Homemaker	Unemployed		Osteoporosis		Psychiatric d/o	Yes/No
Disabled	Retired		Stomach ulcers	Yes/No		Yes/No
Not working du			Thyroid probs	Yes/No	Alcohol abuse	Yes/No
Time lost from wor	rk?Days/Wks/Mo	os/Years	Other:			
ALLERGIES:						<del></del>
	ood, or environmental )				S: (Do you <u>curr</u>	<u>ently</u>
			have any of the j		symptoms?)	
			Abnormal bleed	ing		Yes / No
			Cold hands/feet			Yes / No
			Constipation			Yes / No
			Depression			Yes / No
<b>CURRENT MED</b>	ICATIONS/SUPPLEME	ENTS:	Anxiety/ Panic a	ıttacks		Yes / No
( Please list all med	dications including over-ti	he-	Extreme fatigue			Yes / No
counter, herbal & a	_		Fever, chills			Yes / No
			Muscle spasms			Yes / No
			Shortness of bre	ath		Yes / No
			Skin rashes			Yes / No
			Sleep disturbance	ee		Yes / No
			Stomach pain			Yes / No
			Recent weight g	ain		Yes / No
			Thought Working	*****		100/110

			Page 3
EVIEW OF SYSTEMS (continued)			
nexplained weight loss	Yes / No	Ringing ears	Yes / No
welling of the legs	Yes / No	Restless legs	Yes / No
ritability	Yes / No	Diarrhea	Yes / No
npaired concentration	Yes / No	Gas/bloating	Yes / No
ugar cravings	Yes / No	Bladder infections	Yes / No
rizziness	Yes / No	Brittle nails	Yes / No
Vear glasses or contacts	Yes / No	Chest pain	Yes / No
ther:		Leg cramps	Yes / No
OCATION OF PAIN/ PROBLEM:			



## **SEVERITY OF PAIN:** ( Please circle ONE )

1	2	3	4	5	6	7	8	9	10
	MILD		MODERATE			SEV	ERE		

Thank you for taking the time to complete this Health Questionnaire.

I certify that I have completed the above 3 pages of health information to the best of my ability and that the
information is true.

Patient Signature	Date	
All Forms reviewed on:		

*By:*