Patient Name: _____ **Birthdate:** _____ **Height:** _____

Social Security Number: _____ **Male** **Female** **Weight:** _____

Home Address: _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Who Referred You to Our Office? _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

What are You Seeing the Doctor For? _____ Headache _____ Neck Pain _____ Back Pain _____ Other

Primary Care Physician: _____

May We Send Health Updates to this Physician? _____ Yes _____ No

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company		
Group #		
Subscriber ID:		
Address:		
Insured's Name:		
Insured's Employer:		
Insured's SS#		
Relation / DOB:		

Martial Status: _____ Single _____ Married _____ Divorced _____ Widowed

Current Work Status: _____ Employed _____ Retired _____ Not Working _____ Light Duty

Occupation: _____

Handed: _____ Right _____ Left _____ Both

Have You Seen a Doctor in the Past for These Injuries/Conditions?

Doctor: _____ **Date:** _____ **Treatment:** _____

Doctor: _____ **Date:** _____ **Treatment:** _____

MEDICATIONS

MEDICATIONS	DOSE

ALLERGIES

ALLERGY	SEVERITY (MILD, MODERATE, SEVERE)

PAST SURGERIES

SURGERY	DATE

BACK PAIN

Location:

_____ No back pain
_____ Centrally located low back pain
_____ Right sided low back pain
_____ Left sided low back pain
_____ Both sides into the hips
_____ Between the shoulder blades

Describe Your Pain:

_____ Deep dull
_____ Sharp
_____ Burning
_____ Electric
_____ Hot/tingling
_____ Stiff and sore

When did your back pain begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Duration:

_____ Constant
_____ Intermittent

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for low back pain?

_____ Yes _____ No

Does your pain radiate?

_____ Does not radiate to legs/feet/toes
_____ Radiates into the right leg
_____ Radiates into the left leg
_____ Radiates into the right foot/toes
_____ Radiates into the left foot/toes

How well do you function with your pain?

_____ I have 100% function with usual activities
_____ I have 75% function with usual activities
_____ I have 50% function with usual activities
_____ I have 25% function with usual activities
_____ I cannot function

What makes your pain worse?

_____ Flexion
_____ Extension
_____ Rotating left / right
_____ Laying on back
_____ Coughing / sneezing
_____ Laying on side
_____ Motion

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Exercise and stretching
_____ Rest
_____ Laying on side
_____ Laying on back

NECK PAIN

Location:

_____ No neck pain
_____ Centrally located low neck pain
_____ Right sided low neck pain
_____ Left sided low neck pain
_____ Both sides into the shoulders
_____ At the base of the skull

Describe Your Pain:

_____ Deep dull
_____ Sharp
_____ Burning
_____ Electric
_____ Hot/tingling
_____ Stiff and sore

When did your neck pain begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Duration:

_____ Constant
_____ Intermittent

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for low back pain?

_____ Yes _____ No

Does your pain radiate?

_____ Does not radiate to arms/hands/fingers
_____ Radiates into the right arm
_____ Radiates into the left arm
_____ Radiates into the right fingers
_____ Radiates into the left fingers

How well do you function with your pain?

_____ I have 100% function with usual activities
_____ I have 75% function with usual activities
_____ I have 50% function with usual activities
_____ I have 25% function with usual activities
_____ I cannot function

What makes your pain worse?

_____ Moving head up
_____ Moving head down
_____ Rotating left / right
_____ Motion
_____ Coughing / sneezing

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Rest
_____ Medication

HEADACHES

Location:

_____ No headaches
_____ Forehead
_____ Right side of head
_____ Left side of head
_____ Behind the eyes
_____ Back of head

Describe Your Pain:

_____ Deep pressure
_____ Dull ache
_____ Burning
_____ Throbbing
_____ Hot/tingling
_____ Stiff and sore

When did your headaches begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Frequency:

_____ per week

History:

_____ History of headaches?
_____ Ever suffered a concussion?
_____ Prior epilepsy treatment?
_____ Prior history of seizures?

What makes your pain worse?

_____ Noise
_____ Light
_____ Food
_____ Motion
_____ Coughing / sneezing

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Rest
_____ Medication

OTHER PAIN

Location:

Describe Your Pain:

Intensity:

_____ Mild (1-3)

_____ Moderate (4-7)

_____ Severe (8-10)

Duration:

_____ Constant

_____ Intermittent

When did your pain begin?

_____ After my accident

_____ Years ago (Date) _____

_____ A few days/weeks/months ago

_____ Always had some pain/stiffness

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for low back pain?

_____ Yes _____ No

Does your pain radiate?

How well do you function with your pain?

What makes your pain worse?

What makes your pain better?

REVIEW OF SYSTEMS

Have you noticed any of the following?

_____ Unexpected weight loss or gain

_____ Blurred / double vision

_____ Headache

_____ Chest pain

_____ Shortness of breath

_____ Nausea

_____ Painful urination

_____ Joint pains

_____ Skin rash

_____ Dizziness

_____ Depression

_____ Easy bruising

_____ Excessive thirst or urination

_____ Reaction to foods / environment

PAST MEDICAL HISTORY

Have you had any of the following?

_____ Hypertension

_____ Coronary Artery Disease

_____ Arthritis

_____ Cancer

_____ Overweight

_____ Osteoporosis

_____ Immune Disorder

_____ Other: _____

Do you consume alcohol?

_____ I do not drink _____ I am a recovering alcoholic _____ I drink occasionally

Do you smoke?

_____ Yes _____ No _____ I used to smoke

Do you use recreational drugs?

_____ No _____ I have previously used _____ I currently use

FAMILY HISTORY

Has anyone in your immediate family ever had the following?

_____ Cancer

_____ Stroke

_____ Hypertension

_____ Alcoholism

_____ Bleeding tendency

_____ Other: _____

Everything I have answered is true and correct to the best of my knowledge.

Signature: _____ Date: _____