

Please fill out this form and bring it to the appointment.

Name: _____

MR #: _____

CONFIDENTIAL PATIENT HISTORY QUESTIONNAIRE

IMPRINT AREA

PLEASE PRINT LEGIBLY IN BLACK INK. CHECK, CIRCLE AND FILL IN BLANKS THAT APPLY TO YOU.

NAME				ADDRESS	
HOME PHONE		WORK PHONE			
AGE	HT	WT	SEX	DOMINANT HAND	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Right <input type="checkbox"/> Left	

Where is the main pain problem for which you were referred?
 Neck Back Arm: R L Leg: R L

Approximate date this pain began: _____

How did it begin? (Check all that apply.)

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Woke up with it | <input type="checkbox"/> Pushing/Pulling | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Lifting | <input type="checkbox"/> Assault |
| <input type="checkbox"/> Car Accident | <input type="checkbox"/> Gradually | <input type="checkbox"/> Suddenly |
| <input type="checkbox"/> Other: _____ | | |

Was this work related? Yes No

Was this a worsening of an old injury? Yes No

Current distribution of pain complaints:

- 100% Back or Neck; 0% Arm or Leg
- 50% Back or Neck; 50% Arm or Leg
- 0% Back or Neck; 100% Arm or Leg

Do you have arm/leg weakness? Yes No

Do you have arm/leg numbness? Yes No

Is your pain:

- Continuous
- Intermittent

When is your pain worst?

- Morning
- End of the Day
- Night

Does walking make your pain worse? Yes No

If yes, is this pain in your legs? Yes No

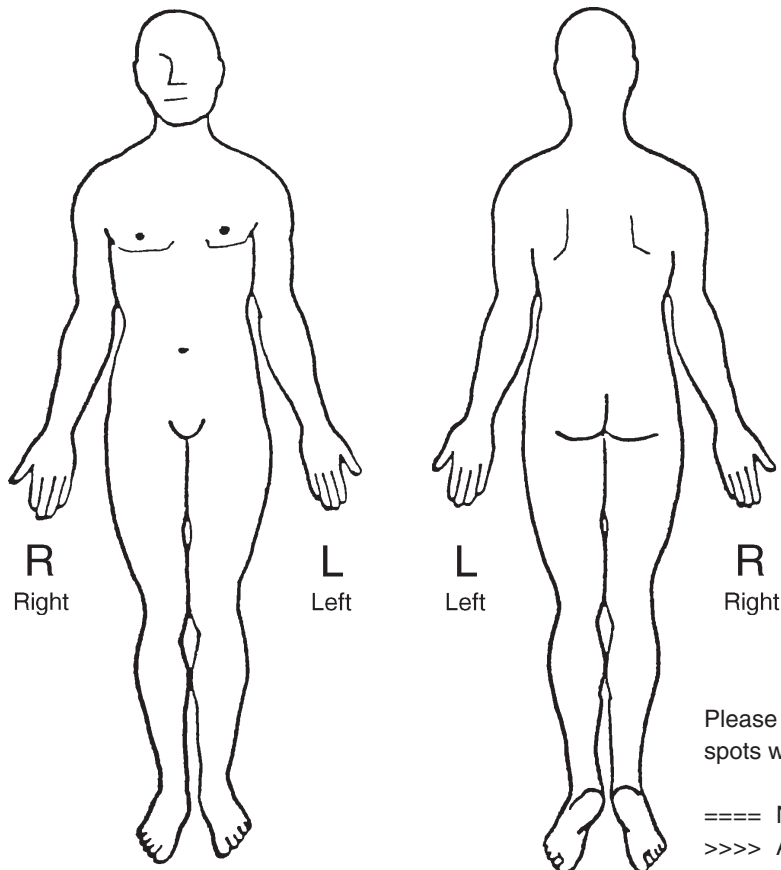
Does coughing or sneezing increase

your pain? Yes No

Do you have problems urinating or moving

your bowels? Yes No

Describe in your own words how this pain started.



Pain Diagram

Please note the orientation of the diagrams below and mark the exact spots where you are experiencing any of the following sensations.

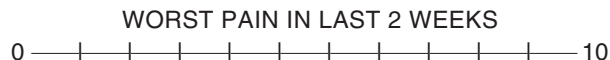
(Please use only the symbols listed.)

- ==== Numbness oooo Pins & Needles xxxx Burning
- >>>> Aching ///// Stabbing

•••• Other, explain: _____

Rate your pain on this scale. (Mark with an X)

0 = No Pain 10 = Worst possible pain



Rate these activities on how your pain is affected:

	Better	Worse	No Difference
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Flat on Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Flat on Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Flat on Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Who else has treated you for this?

- Physical Therapist Chiropractor
 Other: _____

Rate these treatments on how your pain is affected:

	Better	Worse	No Difference
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you do back/neck exercises? Yes No

Do you do them daily? Yes No

Do you do aerobic exercise regularly? Yes No

Do you have any sleep problems? Yes No

If yes: How many hours do you sleep? _____

How many times do you awaken a night? _____

PREVIOUS BACK/NECK INJURY HISTORY

Have you ever had this exact injury before? Yes No

If yes, did you have surgery? Yes No

Have you ever had a back problem before?.. Yes No

Have you ever had a motor vehicle accident? . Yes No

If yes, how many? _____

Was there litigation (lawyers) involved? Yes No

Have you ever filed a Workers' Comp claim? .. Yes No

What part of the body was hurt? _____

Was there litigation (lawyers) involved? Yes No

Have you ever missed any work from a back or neck problem? Yes No

If yes, how much time? _____

Have you ever had back or neck surgery? Yes No

Date	Type of Surgery	Pain Better Afterward	Pain Worse Afterward

WORK HISTORY

Are you:

- Currently Working Permanently Disabled
 Retired Temporarily Disabled

Did you stop working because of your pain? .. Yes No

Current/Recent Employer: _____

Date of Hire: _____

Usual Occupation: _____

Physical Demands of Your Job

- Very Heavy (lift >100 lbs.) Heavy (lift > 50 lbs.)
 Moderate (lift > 30 lbs.) Light (lift 15-30 lbs.)
 Repetitive Hand Tasks Sedentary (No lifting)

Describe your job.

SOCIAL HISTORY

Marital Status

	HOW MANY TIMES?	HOW LONG?
<input type="checkbox"/> Married	_____	_____
<input type="checkbox"/> Divorced	_____	_____
<input type="checkbox"/> Separated	_____	_____
<input type="checkbox"/> Widowed	_____	_____
<input type="checkbox"/> Live with significant other	_____	_____
<input type="checkbox"/> Never Married		

How many children do you have and what are their ages?

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____
7. _____	8. _____	9. _____
10. _____	11. _____	12. _____

Habits: (Check if you have or have ever had the following habits.)

Smoking Cigarettes: Age started _____ # of packs/day _____
 Quit: _____ (when)

Cigars Marijuana Crank

Pipe Cocaine Heroin

Caffeinated Beverages (Coffee, tea, cola) # per day _____

Drinking Alcoholic Beverages: Age started _____
 Last drink _____ (when) # of drinks/week _____

Have you tried alcohol to help your pain? Yes No

EDUCATION:
What is your highest level of education or training?

GENERAL MEDICAL HISTORY

Who is your Primary Care Doctor?

Who referred you to us?

When was your last general physical?

When was your last rectal exam?

FEMALES:
When was your last pelvic exam, Pap smear, breast exam?

What were the results?

Check if you have or had any of these medical problems:

<input type="checkbox"/> Heart Attack/Angina	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Cancer (type: _____)	

LIST ALL SURGERIES AND DATES (not spine related)

Type of Surgery	Date	Type of Surgery	Date

LIST ALL DRUG ENVIRONMENTAL AND FOOD ALLERGIES

LIST ALL MEDICATIONS YOU TAKE (Including nonprescription. {Check those meds that you take for your back/neck.})

Medication	Dosage	Medication	Dosage
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	

GENERAL SYMPTOMS

During the past year, have you had any of the following symptoms?

Symptom:	Explanation:
<input type="checkbox"/> Persistent Fevers	_____
<input type="checkbox"/> Night Sweats	_____
<input type="checkbox"/> Weight Loss (more than 10 lbs.)	_____
<input type="checkbox"/> Multiple Joint Ache	_____
<input type="checkbox"/> Sleep Problems	_____
<input type="checkbox"/> Fatigue	_____
<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Easy Bruising	_____
<input type="checkbox"/> Excessive Bleeding	_____
<input type="checkbox"/> Persistent Diarrhea	_____
<input type="checkbox"/> Constipation	_____
<input type="checkbox"/> Swollen Ankles	_____
<input type="checkbox"/> Dark Stools	_____
<input type="checkbox"/> Blood In Stool	_____
<input type="checkbox"/> Difficulty Urinating	_____
<input type="checkbox"/> Incontinence	_____

Females:	Explanation:
<input type="checkbox"/> Excessive Vaginal Bleeding	_____
<input type="checkbox"/> More Back/Neck Pain With Periods	_____

Is there anything else we should know that could help us take care of you?

To the best of my knowledge, all of the above is true.

SIGNATURE	DATE
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