Name: ____________________________________
Age: ____________ ☐ Male ☐ Female
Date of Birth: ____/____/_______
Appointment Date: ____/____/_______

Primary Doctor's name:______________________
Who referred you?____________________________

Check if you are here for the following?
☐ General Visit ☐ Work Physical Exam
☐ Second **Surgical** opinion ☐ Scoliosis Evaluation
☐ Workmen's Compensation-related injury
☐ Car accident claim ☐ Personal injury Lawsuit

Where do you have the MOST Pain? Check ONE.
☐ Neck ☐ Upper/Mid Back ☐ Low Back
☐ Groin ☐ Tailbone ☐ Buttocks (Left/ Right)
☐ Left Arm / Shoulder ☐ Right Arm / Shoulder
☐ Left Hip / Leg ☐ Right Hip / Leg

My pain has been present for:_________________
☐ About 1 week ☐ Over 6 months
☐ About 1 month ☐ Over 1 year
☐ About 3 months ☐ Over 2 years
☐ Approx 4-6 months ☐ More than 5 years
My pain has been present since __________(year)

If the following applies, then circle the side:
Does the **Pain** go into............**an arm? Right / Left**
or **a leg? Right / Left**
Do you have **Weakness** in....**an arm? Right / Left**
or **a leg? Right / Left**
Do you have **Numbness** in...**an arm? Right / Left**
or **a leg? Right / Left**

Did an INJURY start your pain? **YES / NO**
Was the injury at WORK? **Yes / No**
Was the injury a CAR ACCIDENT? **Yes / No**
Date of injury:_____________________
Do you have a **LAWSUIT** pending? **YES / NO**
Lawyer's name: ___________________
Tell us what injury or event started your pain:
____
____
____

In the LAST 12 MONTHS, have YOU had any:
☐ Stroke ☐ Heart attack ☐ Pneumonia
☐ Loss of bladder control (uncontrolled accidents)
☐ Loss of bowel control (uncontrolled accidents)
☐ Balance problems ☐ Handwriting changes
☐ Increasing clumsiness or weakness of hands
☐ Pain which wakes you up at night.
☐ Night sweats/fevers/chills ☐ STAPH infection
☐ Unexplained weight loss ☐ Blood clots (legs)

How SEVERE is your current PAIN?
(RATE from 1 to 10) Level 10 makes you PASS OUT!
On a ***DAILY basis***, my level of pain is:
0 1 2 3 4 5 6 7 8 9 10 (CIRCLE ONE)
At the ***WORST time***, my level of pain is:
0 1 2 3 4 5 6 7 8 9 10 (CIRCLE ONE)

Which other doctors you have seen for this pain:
☐ **Chiropractor**_______________________________
☐ **Family M.D.**_______________________________
☐ **Emergency Room**___________________________
☐ **Pain Management** __________________________
☐ **Neurologist**_______________________________
☐ **Neurosurgeon**______________________________
☐ **Other**____________________________________

CHECK the Treatments you have already tried for this Pain. *CIRCLE* how treatment helped you?
☐ **Acupuncture:** Helped Did not help Maybe helped
☐ **Brace:** Helped Did not help Maybe helped
☐ **Chiropractic:** Helped Did not help Maybe helped
☐ **Home exercises:** Helped Did not help Maybe
☐ **Physical Therapy:** Helped Did not help Maybe
☐ **Spine Traction:** Helped Did not help Maybe
☐ **Steroid pills:** Helped Did not help Maybe
☐ **Steroid injections:** Helped Did not help Maybe
☐ **TENS:** Helped Did not help Maybe

CIRCLE the drugs you were tried for this pain:

Ibuprofen	Relafen	Lodine	Feldene
Ultram	Mobic	Naproxyn	Celebrex
Flexeril	Xanaflex	Baclofen	Soma
Vicodin	Lortab	Oxycontin	Morphine
Medrol pack	Lyrica	Gabapentin	Elavil

Other ______________________________________

Check if you had these tests in the past 2 years?

- ☐ Spine xrays ☐ Spine MRI
- ☐ Spine CT scan ☐ Spine CT myelogram
- ☐ Diskogram ☐ Nerve study (EMG/NCV)
- ☐ Nerve root blocks ☐ Dexa Scan (Bone density)
- ☐ Epidural spinal injections ☐ Bone scan

With the following activities, how is your pain?

	Better	Worse	Unchanged
Cough or sneeze	☐	☐	☐
Sitting for 30 min	☐	☐	☐
Standing for 30 min	☐	☐	☐
Walking for 15-30 min	☐	☐	☐
Bending forward	☐	☐	☐
Leaning backwards	☐	☐	☐
Lying flat on back	☐	☐	☐
Lying on side & knees bent	☐	☐	☐
Waking in the morning	☐	☐	☐
Middle of the night	☐	☐	☐

Please *CIRCLE* the best answer as to your ability to function in the following situations.

ACTIVITES OF DAILY LIVING (PERSONAL CARE)

1. I can look after myself normally.
2. I can look after myself with some pain
3. I need some help with my personal care
4. I need help every day in most aspects of my care
5. I do not get dressed and stay in bed

WALKING

1. I can walk any distance without problem.
2. Pain prevents me from walking more than 1 mile
3. Pain prevents me from walking more than ½ mile
4. Pain prevents me from walking more than ¼ mile
5. I am restricted to bed and have to crawl to the toilet

SITTING

1. I can sit in any chair as long as long as I like.
2. I cannot sit more than 1 hour
3. I cannot sit more than ½ hour
4. I cannot sit more than 10 minutes
5. I cannot sit at all & prefer to stand/walk.

SOCIAL LIFE or TRAVEL

1. My social life/travel is normal with no pain
2. My social life/travel is normal with some pain
3. My social life/travel is moderately limited
4. My pain limits my social life and I do not go out often
5. I have no social life & cannot travel because of pain

NECK TO ARM PAIN RATIO

(Complete only if your visit TODAY is about your Neck or Arm pain)

Is your neck pain worse than arm pain? YES NO
Is your arm pain worse than neck pain? YES NO

Please CIRCLE ONLY ONE of the ratios listed below which BEST describes the amount of pain you feel in your neck as compared to your arm(s).

I only have 100% neck pain and NO arm pain
90% neck pain compared to 10% arm pain
80% neck pain compared to 20% arm pain
70% neck pain compared to 30% arm pain
60% neck pain compared to 40% arm pain
50% neck pain compared to 50% arm pain
40% neck pain compared to 60% arm pain
30% neck pain compared to 70% arm pain
20% neck pain compared to 80% arm pain
10% neck pain compared to 90% arm pain
I have NO neck pain just 100% arm pain

BACK TO LEG PAIN RATIO

(Complete only if your visit TODAY is about your Back or Leg pain)

Is your back pain worse than leg pain? YES NO
Is your leg pain worse than back pain? YES NO

Please CIRCLE ONLY ONE of the ratios listed below which BEST describes the amount of pain you feel in your back as compared to your leg(s).

I only have 100% back pain and NO leg pain
90% back pain to 10% leg pain
80% back pain to 20% leg pain
70% back pain to 30% leg pain
60% back pain to 40% leg pain
50% back pain to 50% leg pain
40% back pain to 60% leg pain
30% back pain to 70% leg pain
20% back pain to 80% leg pain
10% back pain to 90% leg pain
I have NO back pain just 100% leg pain

PAST MEDICAL HISTORY

Please (CIRCLE) if you currently have, or have had in the past, any of these medical conditions?

AIDS
Aortic Aneurysm or Aortic Surgery
Alcohol Addiction
Alzheimer's Dementia
Angina (Coronary Artery Disease)
Anxiety
Arthritis of the shoulders
Arthritis of the hips
Arthritis of the knees
Asthma
Brain Surgery (what type?______________________)
Bipolar Disorder
Cancer (what type?_____________________________)
Carpal Tunnel Syndrome or Surgery
COPD (Bronchitis)
Carotid artery blockage or Carotid Surgery
Depression
Diabetes
Diabetic ulcers on feet
Drug Addiction
Fibromyalgia
Heart Attack
Heart Disease
Hepatitis
High blood pressure / Hypertension
High Cholesterol
HIV Positive
Kidney Disease
Kidney Failure on Dialysis
Kidney Stones
Liver Disease
Lyme Disease
Lupus
Osteoporosis
Osteomyelitis (deep bone infection)
Pancreatitis
Parkinson's Disease
Polio
Radiation treatments
Rheumatoid Arthritis
Spinal Fractures / Broken bones in the Spine
Staph skin infection
Stroke
Surgical infections (after any surgery)
Tuberculosis (TB)
Ulcers (stomach)
Other:____

PLEASE LIST ALL YOUR PAST SURGERIES:

____
____
____
____
____
____

Have you had SPINE (neck or back) SURGERY?
YES NO
(IF YES, give type, surgeon and year performed.)
____
____
____
____

Have you had any surgery in the front of your neck or into your belly/abdomen? **YES NO**
(If yes, then what type of surgery was performed.)
____
____
____

MEDICATIONS

Are you ALLERGIC to ANY MEDICATIONS?
YES NO
If YES, then CIRCLE below or list your allergies:

Betadine	Iodine contrast	Steroids
Shell fish	Anesthesia	NSAIDs
Penicillin	Codeine	Sulfa

____
____
____
____

Write down ALL the medications or herbal or vitamin supplements you are TAKING?
(If more than 10 meds, then pls give us a written list)
____
____
____
____
____
____
____
____
____

FAMILY HISTORY

Please CIRCLE if your family has a history of:

Cancer
Diabetes
High blood pressure
Heart Disease
Arthritis
Rheumatoid Arthritis
Spinal problems
Osteoporosis
Scoliosis
Anesthetic Reactions

Do you presently smoke/chew tobacco? **YES NO**
Have you chewed or smoked tobacco? **YES NO**
If YES, number of YEARS chewing or smoking: _____
How many packs of cigarettes per day? **1 2 3**
QUIT tobacco? Which year did you quit? _________

SOCIAL HISTORY

What is your Marital Status:
Single Married Divorced Widowed
Number of Children: _________

What is your JOB or PROFESSION?
____

If **not presently working or employed**, then when was the last time you worked: ______________________

Do you drink ALCOHOL? **YES NO**
If yes, how many drinks per week do you take:
1-2 3-6 7-10 11-20 more than 20
If you quit alcohol, did you have a drinking problem at that time? **YES NO**

Have you used illegal or street DRUGS? **YES NO**
If YES, which drugs did you take or abuse:
Marijuana Cocaine Crack Heroin PCP
Methamphetamine Prescription Pain Meds
If you quit drug use, did you go to Rehab? **YES NO**

REVIEW OF SYSTEMS

Please CIRCLE if you also currently have any of the following problems.

Constitutional:
Fatigue
Fevers
Night Sweats
Weight gain
Weight loss (unplanned)
Cancer (where?)_________________

Cardiovascular:
Chest pain (heart-related)
Heart murmur
Irregular heartbeat / palpitations
Leg /ankle swelling
Passing out / Blackouts
Claudication (leg pain when walking)

Skin:
Contact allergy
Rash
Skin infections
Skin lesion/cancer
Tattoos

Head & Neck:
Vision loss
Trouble swallowing food/drinks
Facial pain
Migraines
Persistent Headaches
Hearing loss
Voice hoarseness / changes
Ringing in ears (tinnitus)
Vertigo

Gastrointestinal:
Abdominal pain
Constipation
Diarrhea
Heartburn
Loss of appetite
Nausea
Vomiting
Blood in your stool

Neurological:
Difficulty walking
Dizziness
Poor coordination / balance
Memory loss
Muscle weakness
Seizures
Tremors
Stroke

Psychiatric:
Anxiety
Bipolar disorder
Depression
Suicide attempts
Insomnia

Hematologic:
Anemia (low blood count)
Bleeding does not stop in usual time
Easy bruising of arms or legs
Blood clots in your legs

Respiratory:
Chest pain when taking deep breaths
Cough
Shortness of breath
Recent lung infection / pneumonia
TB infection or exposure
Blood clot in your lungs
Wheezing

Genitourinary:
Painful urination
Blood in urine
Poor control of urination
Urinary accidents in bed or in clothes
Impotence
Erecticle Dysfunction

Immunological:
Asthma
Allergies – Food
Allergies – Hayfever
AIDS or HIV positive

Your Current Height
______ Ft _______inches
Your Current Weight
______ pounds