

Which of the following have you had for your low back / mid-back / neck?	Did the treatment make you:					
	Low Back	Mid-Back	Neck	Better	No Change	Worse
Physical Therapy						
Occupational Therapy						
Chiropractic / Osteopathic						
Massage						
Brace						
Biofeedback						
Acupuncture						
Herbs						
Injections:						
Trigger Point						
Epidural / Facet						
Nerve Root						
Regular X-rays						
MRI Scan						
Myelogram						
CT Scan						
Bone Scan						
EMG / NCV						

Check all of those that apply to you:

- Bowel Function: ___ Normal ___ Loss of control or accidents ___ Constipation
- Bladder Function: ___ Normal ___ Loss of control or accidents ___ Difficulty starting or stopping urination ___ Sense of urgency
- Leg / Foot: ___ Normal ___ Weakness (Right / Left)
- Arm / Hand: ___ Normal ___ Weakness (Right / Left)

It is normal for patients faced with daily pain to experience emotional reactions such as worry, frustration and sadness. Please circle the appropriate number to indicate the extent that you are troubled by the following:

	NONE					SEVERE					
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10

I currently take medications for anxiety or depression: Yes No

I have received counseling for anxiety or depression: Yes No

PRIOR MEDICAL HISTORY

List **ALL** allergies to medications:

MEDICATION	REACTION	MEDICATION	REACTION

List **ALL** medications (**prescription and non-prescription**) you currently take:

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE

List all medications **previously** taken for your pain _____.

Gastrointestinal: Do you have ulcers? ____ Yes ____ No Has your ulcer bled? ____ Yes ____ No
 Do you have reflux, hiatal hernia or GERD? ____ Yes ____ No

Alcohol / Drugs: What is your approximate weekly use of alcoholic beverages?

- ____ I don't drink alcohol
- ____ Less than 1-2 drinks a week
- ____ 3-6 drinks a week
- ____ Drink some alcohol on a daily basis

Have you or a parent ever had a problem with:

Alcoholism: ____ You ____ Parent ____ No • Drug Abuse: ____ You ____ Parent ____ No

Tobacco: What is your approximate daily use of tobacco?

- ____ I don't smoke
- ____ 1 pack per day
- ____ More than 2 packs per day
- ____ ½ pack per day
- ____ 1-2 packs per day

OB/GYN: (Women Only)

Date of last period: _____ ____ Normal ____ Abnormal ____ Hysterectomy / Postmenopausal/Premenopausal
Date of last pelvic exam: _____ ____ Normal ____ Abnormal
Date of last PAP Smear: _____ ____ Normal ____ Abnormal
____ Yes ____ No Pregnant or possibly pregnant • ____ Yes ____ No Breast-feeding

CURRENT MEDICAL PROBLEMS: Please list

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____
- 9) _____

PRIOR SURGERY: Please list

TYPE	DATE	TYPE	DATE

FAMILY HISTORY:

	Living (Yes / No)	Present health issues or cause of death
Father	Yes No	_____
Mother	Yes No	_____
Spouse	Yes No	_____
Brothers	# Living ____	_____
	# Deceased ____	_____
Sisters	# Living ____	_____
	# Deceased ____	_____
Children	# Living ____	_____
	# Deceased ____	_____

Review of Systems: Please put an "X" next to any of the symptoms you have had during the past year.

- | | | |
|---|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Unusual stress in home life | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Unusual stress in work life | <input type="checkbox"/> Persistent diarrhea |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Any lumps in neck, armpits or groin | <input type="checkbox"/> Excessive constipation |
| <input type="checkbox"/> Problems with sexual function | <input type="checkbox"/> Chest pain or tightness | <input type="checkbox"/> Dark black stools |
| <input type="checkbox"/> Loss of sensation around groin or buttocks | <input type="checkbox"/> Persistent or unusual cough | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Unexplained fevers | <input type="checkbox"/> Trouble breathing with exercise | <input type="checkbox"/> Pain or burning when urinating |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Trouble breathing lying flat | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Weight loss of 10 pounds or more | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Need to urinate more at night |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Swollen ankles | |
| <input type="checkbox"/> Excessive fatigue | <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Persistent eye redness |
| <input type="checkbox"/> Problems with depression | <input type="checkbox"/> List joints: _____ | <input type="checkbox"/> Dry eyes or mouth |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Muscle tenderness | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Generalized morning stiffness | |
| <input type="checkbox"/> Decreased Concentration | <input type="checkbox"/> Easy bruising | |
| <input type="checkbox"/> Memory Difficulties | <input type="checkbox"/> Excessive bleeding | |

Work: Employer: _____ Your job title: _____ Date last worked: _____

Work status at the time of:	<u>Injury Onset</u>	<u>Currently</u>
On disability	_____	_____
Regular: full-time	_____	_____
Regular: part-time	_____	_____
Permanent light duty	_____	_____
Temporary light duty	_____	_____
Temporarily totally disabled (not working)	_____	_____
Retired	_____	_____

- How physically demanding is your job?
- Very heavy (frequently lifting > 100 pounds)
 - Heavy (frequently lifting > 60 pounds)
 - Moderate (frequently lifting > 30 pounds)
 - Light (frequently lifting < 30 pounds)
 - Sedentary (essentially no lifting)

- How satisfied are you with your job?
- Very satisfied
 - Satisfied
 - Dissatisfied
 - It is the worst job I've ever had

Social: What are some of your usual recreational activities that you had participated in the **YEAR BEFORE** your current problem? **Place an "X" in front of those you currently cannot perform.**

() _____ () _____
 () _____ () _____

Education: (Circle highest level attained) Did Not Finish High School / High School / College / Post Graduate

Attorney: Does an attorney assist you with your injury claim? Yes No Name: _____

Primary Care Physician: Name: _____

Address: _____

Please inform me if any portion of the physical examination that I will perform causes you pain. Please do not perform any motion that causes your symptoms to worsen. An initial evaluation will occasionally increase your symptoms since painful structures are being evaluated.

Please sign and date this form.

 Patient's signature
Record Review: Yes / NO

 Date

 Physician's signature
X-Ray Review: Yes / NO

 Date