



	Which of the following have you had for your low back / mid-back / neck?				Did the treatment make you:		
	Low Back	Mid-Back	Neck	Other	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

Yes | No | Was this a problem for you prior to having the pain for which you are seeing us today?

Yes | No | If so, is it worse since developing this pain?

Yes | No | Do you currently take medication for anxiety or depression?

Yes | No | Have you received counseling for anxiety or depression?

Yes | No | Do you have a history of psychological disease? (ie: ADD, Obsessive Compulsive Disorder, Bipolar, Schizophrenia)

Please specify: \_\_\_\_\_

**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) \_\_\_\_\_ 4) \_\_\_\_\_ 7) \_\_\_\_\_
- 2) \_\_\_\_\_ 5) \_\_\_\_\_ 8) \_\_\_\_\_
- 3) \_\_\_\_\_ 6) \_\_\_\_\_ 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                   | 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:	Injury Onset	Currently
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