

Name: _____



Date of birth: _____

Referring Doctor: _____
DOB: _____ Age: _____ Sex: M / F
Height: _____ Weight: _____ Marital Status: S M D W

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

Tell us about your symptoms

Date of injury: _____

What are your symptoms? _____

Is this pain mostly in back, neck or elsewhere? _____

How long ago did the symptoms begin? _____

Is the pain constant, or does it come and go? _____

How do these symptoms limit you? _____

What things make the pain better (rest, ice, heat, pills)? _____

What makes the pain worse? _____

Do you have pain that radiates into the arm or leg?

Yes No Describe: _____

Have you lost any control over bowel or bladder functions?

Yes No Describe: _____

Do you have any weakness or numbness in an arm or leg?

Yes No Describe: _____

How long can you: sit _____ stand _____ walk _____

Is your pain the result of a: Fall Auto accident Injury on the job

Other: _____

Which of the following describes you currently?

- Working
- Not working because of back or neck problem
- Not working because of another health problem
- Homemaker, retired or unemployed

How long have you been at that job? _____

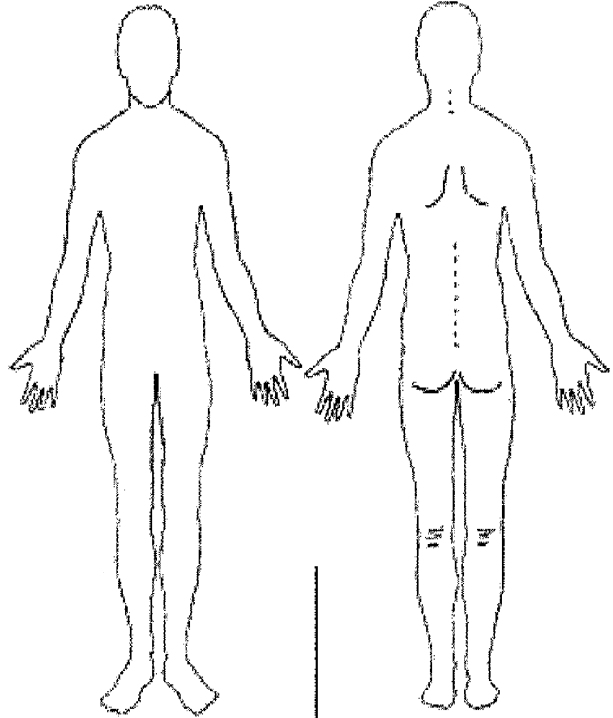
Does your job require lifting, standing, sitting? _____

Employer at time of injury _____

Is there a law suit pending on problem? Yes No

Front

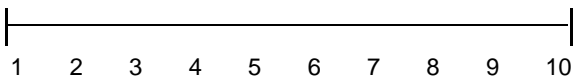
Back



Stabbing pain ////
 Burning pain oooo
 Aching pain xxxx
 Numbness =====

Stabbing pain ////
 Burning pain oooo
 Aching pain xxxx
 Numbness =====

Circle your pain level on a scale of 1 to 10, with 10 being unbearable, or worst imaginable, pain.



No Pain

Extreme Pain

Name: _____



Date of birth: _____

Who treated you first for this problem? Dr. _____ City: _____

What treatment did you have then? _____

What tests have you had? CT Scan MRI X-ray EMG

Other _____

Did you have any injections for your problem?

Yes No Describe _____

Did these injections help?

Yes No Describe _____

Did you have previous back or neck surgery?

Yes No Describe _____

Did you have physical therapy for your problem?

Yes No Describe _____

Did this therapy help?

Yes No Describe _____

Do you do any special exercises for your back or neck? _____

Have you tried anything else for the pain? No Ice Brace Therapy Chiropractic Massage

What are the hobbies/sports that you participate in _____

Does your pain limit your participation in these? Yes No How? _____

Do you have pain at rest? Yes No

Do you have pain at night? Yes No

Have you taken any medication for the pain? Yes No List _____

What do you hope we can accomplish today? _____