Todays Date:_____

Name:_____

Age:_____
Height:_____
Weight:_____

Please Check Box if you have any chronic medical problems or illnesses?

- Diabetes
- High blood pressure
- Depression
- Asthma
- COPD
- Heart disease
- Arthritis
- Cancer
- Chronic kidney disease
- Liver disease
- Bleeding disorder

Have you had any operations? No/Yes (please list date and procedure below)

_____

_____

List all medications you are currently taking: (Please include Medication, Dosage and Frequency)

_____

_____

Do you have any allergies to medication? No/Yes (please list below)

_____

Do you smoke? No/Yes How many cigarettes per day? _____

Do you drink alcohol? No/Yes How Much? _____

Do you use recreational or herbal drugs? No/Yes List:_____

What kind of work do you do? _____

Is your injury work related? No/Yes If yes, Date of Injury: _________

Referring Physican: _____

Primary Care Physican:_____

PLEASE CHECK ALL ANSWERS AND FILL IN BLANKS WHERE APPROPRIATE

Please describe your problem and how it began: Date:___/___/___

How bad is the pain? (circle a number) 0 1 2 3 4 5 6 7 8 9 10

No pain Unbearble Pain

How often are your symptoms present:

Constantly More than 50% of time 25%-50% Less than 50% of time

Do you have headache? Yes / No

How bad is the headache? [Circle: 0 to 10]

0 1 2 3 4 5 6 7 8 9 10

Do you have neck pain? Yes / No

How bad is the neck pain [Circle: 0 to 10]

0 1 2 3 4 5 6 7 8 9 10

Does the neck pain radiate into your arm? If so, check which: (check box)

- Right
- Left
- Both

Which is worse, the neck pain or the arm pain? _____

Do you have numbness or tingling in your arms? If so, check which: (check box)

- Right
- Left
- Both

Do you have back pain? Yes / No

How back is the back pain? [Circle: 0 to 10]

0 1 2 3 4 5 6 7 8 9 10

Does the back pain radiate into your hip, buttock, or leg? If so, check which:

- Right
- Left
- Both

Which is worse, the back pain or the leg pain?

Do you have numbness or tingling in your legs: If so, check which:

- Right
- Left
- Both

Since It began, is your problem: Improving Getting Worse No change

What makes the problem better? Nothing Standing Exercise Lying Down
Sitting Movement Walking Resting

What makes problem worse? Nothing Standing Exercise Lying Down
Sitting Movement Walking Resting

Can you perform your daily home activities? Yes Only with Help Not at all

Can you perform your daily work activities? Yes, all activities Only with Help Not at all

Have you had surgeries in the past? If so please list procedure and dates:_____

Have you had physical therapy in the past? If so where: _____

Have you had injections in the past? If so on Neck or Back (circle one)

Have you had chiropractic treatment in the past? If so on Neck or Back (circle one)

PLEASE CIRCLE ANY OF THE CONDITIONS THAT OCCUR IN YOUR FAMILY

Diabetes, tuberculosis, heart disease, high blood pressure,stroke, kidney disease, cancer, arthristis, anemia, headaches, epilepsy,mental illness.

PLEASE CIRCLE ANY SYMPTOMS THAT YOU HAVE:

General:	Fever, chills, bleeding, weight change, fatigue
Skin:	Rash, jaundice, ithcing, sores
Hematologist:	Anemia, easy bleeding, easy brusing
Head:	Headache
Eyes:	Change in vision, double vision
Ears:	Hearing Change, ringing in ears,earaches
Throat:	Sore throat, bleeding gums, hoarseness
Lung:	Cough, shortness of breath, wheezing
Heart:	Chest Pain, palpitation, swollen feet
Gastrointestinal:	Difficulty swallowing, nausea/vomiting, diarrhea, constipation
Genitourinary:	Difficulty urinating, urinary frequency, impotence
Musculoskeletal:	Painful or swollen joints, stiffness, back pain, neck pain
Neurologic:	Weakness,dizziness,tingling,difficulty walking
Psychiatric:	Anxiety, depression, alcohol dependence