Patient Name: ______________________________________

Date: _____________________________________________

1. Is today's problem caused by:
   - ☐ Auto Accident
   - ☐ Workman's Compensation
   - Other: ___________________________

2. Indicate (circle or X) on the drawings below where you have pain/symptoms

3. How often do you experience your symptoms?
   - ☐ Constantly (76-100% of the time)
   - ☐ Occasionally (26-50% of the time)
   - ☐ Frequently (51-75% of the time)
   - ☐ Intermittently (1-25% of the time)

4. How would you describe the type of pain?
   - ☐ Sharp  ☐ Numb  ☐ Dull  ☐ Tingly
   - ☐ Diffuse  ☐ Sharp with motion  ☐ Achy
   - ☐ Shooting with motion  ☐ Burning
   - ☐ Stabbing with motion  ☐ Shooting
   - ☐ Electric like with motion  ☐ Stiff
   - Other: ___________________________

5. How are your symptoms changing with time?
   - ☐ Getting Worse  ☐ Staying the Same
   - ☐ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
   0  1  2  3  4  5  6  7  8  9  10 (Please circle)

7. How much has the problem interfered with your work?
   - ☐ Not at all  ☐ A little bit  ☐ Moderately
   - ☐ Quite a bit  ☐ Extremely

8. How much has the problem interfered with your social activities?
   - ☐ Not at all  ☐ A little bit  ☐ Moderately
   - ☐ Quite a bit  ☐ Extremely

9. Who else have you seen for your problem?
   - ☐ Chiropractor  ☐ Neurologist
   - ☐ Primary Care Physician  ☐ ER physician
   - ☐ Orthopedist  ☐ Massage Therapist
   - ☐ Physical Therapist  ☐ No one
   - Other: ___________________________

10. How long have you had this problem?
    ____________________________________________
11. How do you think your problem began?
_______________________________________________
_______________________________________________
_______________________________________________

12. What aggravates your problem?
_______________________________________________
_______________________________________________
_______________________________________________

13. What alleviates your problem?
(makes it feel better)
_______________________________________________
_______________________________________________
_______________________________________________

14. What concerns you the most about your problem; what does it prevent you from doing?
_______________________________________________
_______________________________________________
_______________________________________________

15. What is your:
Height ___________ Weight ___________
Date of Birth _____/_____/______
Occupation ____________________________________________

16. How would you rate your overall Health?
☐ Excellent    ☐ Very Good    ☐ Good    ☐ Fair    ☐ Poor

17. What type of exercise do you do?
☐ Strenuous    ☐ Moderate    ☐ Light    ☐ None

18. Indicate if you have any immediate family members with any of the following:
☐ Rheumatoid Arthritis    ☐ Diabetes    ☐ Lupus
☐ Heart Problems    ☐ Cancer    ☐ ALS

19. List all prescription medications you are currently taking:
___________________________________________
___________________________________________

20. List all of the over-the-counter medications you are currently taking:
___________________________________________

21. List all surgical procedures you have had:
___________________________________________

22. What activities do you do at work?
Sit: ☐ Most of the day ☐ Half the day ☐ A little of the day
Stand: ☐ Most of the day ☐ Half the day ☐ A little of the day
Computer work: ☐ Most of the day ☐ Half the day ☐ A little of the day
On the phone: ☐ Most of the day ☐ Half the day ☐ A little of the day

23. What activities do you do outside of work?
___________________________________________
___________________________________________

24. Have you ever been hospitalized?
☐ No    ☐ Yes
If yes, why ____________________________________________

25. Have you had significant past trauma?
☐ No    ☐ Yes
26. For each of the conditions listed below, place a check in the **past** column if you have had the condition in the past. If you presently have a condition listed below, place a check in the **present** column.

<table>
<thead>
<tr>
<th>Past Present</th>
<th>Past Present</th>
<th>Past Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td>Kidney Disorders</td>
<td>Abdominal Pain</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Depression</td>
<td>Joint Pain/Stiffness</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Wrist Pain</td>
<td>Ulcer</td>
</tr>
<tr>
<td>Neck Pain</td>
<td>Bladder Infection</td>
<td>Arthritis</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>Systemic Lupus</td>
<td>Hepatitis</td>
</tr>
<tr>
<td>Excessive Thirst</td>
<td>Hand Pain</td>
<td>Rheumatoid Arthritis</td>
</tr>
<tr>
<td>Upper Back Pain</td>
<td>Painful Urination</td>
<td>Liver/Gall Bladder Disorder</td>
</tr>
<tr>
<td>Chest Pains</td>
<td>Epilepsy</td>
<td>Cancer</td>
</tr>
<tr>
<td>Frequent Urination</td>
<td>Hip Pain</td>
<td>General Fatigue</td>
</tr>
<tr>
<td>Mid Back Pain</td>
<td>Loss of Bladder Control</td>
<td>Tumor</td>
</tr>
<tr>
<td>Stroke</td>
<td>Dermatitis/Eczema/Rash</td>
<td>Muscular In-coordination</td>
</tr>
<tr>
<td>Smoking</td>
<td>Upper Leg Pain</td>
<td>Asthma</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>Prostate Problems</td>
<td>Visual Disturbances</td>
</tr>
<tr>
<td>Low Back Pain</td>
<td>HIV/AIDS</td>
<td>Chronic Sinusitis</td>
</tr>
<tr>
<td>Angina</td>
<td>Knee Pain</td>
<td>Dizziness</td>
</tr>
<tr>
<td>Drug/Alcohol Dependence</td>
<td>Abnormal</td>
<td></td>
</tr>
<tr>
<td>Shoulder Pain</td>
<td>Weight Gain/Loss</td>
<td></td>
</tr>
<tr>
<td>Kidney Stones</td>
<td>Ankle/Foot Pain</td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td>Loss of Appetite</td>
<td></td>
</tr>
<tr>
<td>Elbow/Upper Arm Pain</td>
<td>Jaw Pain</td>
<td></td>
</tr>
</tbody>
</table>

☐ Other __________________________________________

27. Anything else pertinent to your visit today?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Patient Signature ___________________________________________________________ Date: ____________________