NAME _____ **Date**_____

HEIGHT _____

WEIGHT_____

1. **When did your present symptoms begin (approximately)? Date: ____/____/_____**
2. **Was there a specific event or trauma that brought on your symptoms? YES / NO**
   If yes, describe:_____
3. **Have you had similar symptoms in the past?** YES NO
4. **Did you have surgery?** YES NO
   If yes, on what date? ____/____/_____ What kind of surgery?_____
5. **What symptoms bring you into the clinic today?**_____
6. **Was this a work-related injury?** YES NO
   If yes, describe:_____
7. **Does your problem affect your sleep?**YES NO
8. **Numeric Pain Rating Scale:**

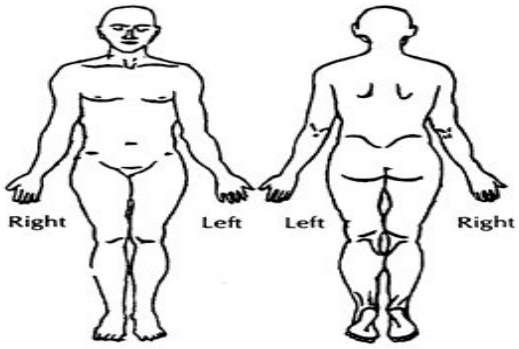
*Circle **one** number for each scale below. 0 indicates "no pain" and 10 indicates "extreme/severe pain"

Please rate your pain level worst: 0 1 2 3 4 5 6 7 8 9 10

Please rate your pain level at current: 0 1 2 3 4 5 6 7 8 9 10

Please rate your pain level at best: 0 1 2 3 4 5 6 7 8 9 10

9. **Use the "X" symbol to mark your symptomatic area(s) on the body chart below.**



10. **How would you describe your pain?** (Cricle all that apply)
    Sharp Dull/Achy Shooting Numb/Tingling Burning Other:_____

11. **Do any of the following activities AGGRAVATE your symptoms?** (Circle all that apply)
    Sitting Standing Walking Stairs Bend Cough/sneeze
    Sit to Stand Twisting lying Down Deep Breath Eating foods Other:_____
12. **What helps EASE your symptoms?** (Circle all that apply)
    Ice Heat Medication Sitting Standing Lying Down Other:_____
13. **When are your symptoms best?** (Circle one)
    morning afternoon evening no change
14. **Since your symptoms began are they getting:** (Circle one)
    better worse no change
15. **Have you had a fall in the last year?** YES NO
    If yes, did you sustain an injury from the fall? YES NO
16. **Have you had 2 or more falls in the last year?** YES NO

17. <u>Have you RECENTLY experienced any of the following:</u> (circle all that apply)

Fatigue Weight change Fever/chills/sweats Dizziness Nausea - continued next page
Weakness
Balance Problems Changes in mentation Malaise
Difficulty urinating Irregular menstrual cycle numbness/tingling
Change in bowel/bladder Shortness of breath Headaches
Abdominal pain Change in urine color

18. <u>Have you EVER had, or been told you have, any of the following?</u> (Circle all that apply)

Cancer	Osteoarthritis	Neurologic Disorders
Diabetes Type I	Rheumatoid Arthritis	Lung Disease
Diabetes Type II	Osteoporosis	Liver/Kidney problems
Angina/Chest pain	Blood clot	Acid reflux
Shortness of breath	Asthma/Allergies	Abdominal pain
Fibromyalgia	Circulation Problems	Ulcers
Stroke	Multiple Sclerosis	Parkinson's Disease
Heart Disease	Pregnant	Pacemaker

19. Are you CURRENTLY receiving any other treatment for this or any other condition (home health, Speech therapy, physical therapy, chiropractic., etc)? YES NO

If yes, what kind of treatment?_____

20. Have you had PREVIOUS treatment as described above for this problem? YES NO

If yes, what kind of treatment?_____

21. Have you EVER had surgery?YES NO

If yes, please list type and approximate date _____

_____

22. How often do you exercise: seldom/never 1-2 times per week 3 or more times per week

23. How many drinks do you have per week? _____

24. Do you smoke? YES NO

25. <u>Have you had imaging studies?</u> (circle all that apply)

None XRAY MRI CT Scan Other:_____

26. Have you EVER used corticosteroid medication (such as prednisone or cortisone)? YES NO

27. <u>Current Medications:</u>

28. <u>Please check your response to each of the following questions:</u>

During the past month have you often been bothered by feeling down, depressed or hopeless? YES NO

During the past month have you often been bothered by little interest or pleasure in doing things? YES NO

If yes to above, have you recently had thoughts of harming yourself or others? YES NO

30. Please list 3 normal activities that you are now limited in performing due to this current problem:

1._____

2._____

3._____