



PATIENT HISTORY FORM

Name: _____ Age: _____ Date: _____

Regarding Your Family Doctor/Internist:

Name: _____

Address: _____

City, State, Zip: _____

Send them a letter? Yes No

Who referred you to us?

Name: _____

Address: _____

City, State, Zip: _____

Send them a letter? Yes No

Are you employed? _____ Yes _____ No

Are you married? _____ Yes _____ No

Occupation: _____

Number of Children: _____ Ages: _____

Check all that apply:

_____ Injury on the job

_____ Auto accident injury

_____ Receiving disability income

_____ Legal proceedings pending

_____ Receiving worker's comp.

_____ Working with a rehab nurse

Does this problem keep you from working? _____ Yes _____ No (If yes, date last worked: _____)

Describe the onset on your problem: Date of onset: _____

Describe "Prior" injuries to your back. Include all Treatments and Outcomes:

How long have you had neck/back pain? _____ years _____ months, _____ weeks

How long you have had arm/leg pain? _____ years _____ months, _____ weeks

CIRCLE THE NUMBER ON THE LINE BEST DESCRIBING YOUR CURRENT BACK OR NECK PAIN:										
0	1	2	3	4	5	6	7	8	9	10
no					moderate					severe
pain					pain					pain

CIRCLE THE NUMBER ON THE LINE BEST DESCRIBING YOUR CURRENT LEG OR ARM PAIN:										
0	1	2	3	4	5	6	7	8	9	10
no					moderate					severe
pain					pain					pain

Describe the Character (quality) of your Pain: _____										
_____ Aching	_____ Sharp	_____ Exhausting	_____ Vicious							
_____ Throbbing	_____ Pinching	_____ Tingling	_____ Penetrating							
_____ Burning	_____ Punishing	_____ Lacerating	_____ Tearing							
_____ Dull	_____ Shooting	_____ Stabbing	_____ Pressure							

Reviewed with Patient: _____
Physician Signature: _____ Date: _____

Have you: (Check all that Apply)

seen a neurosurgeon	Diagnosis:	Name:
seen an orthopedic spine surgeon	Diagnosis:	Name:
seen a neurologist	Diagnosis:	Name:
seen a pain clinic doctor	Diagnosis:	Name:
seen a rehab physician	Diagnosis:	Name:
seen a psychiatrist/psychologist	Diagnosis:	Name:
seen a chiropractor	Diagnosis:	Name:
had chiropractic manipulations	Did it Help? ___ Yes ___ No	
How many weeks _____	Exercise? ___ Yes ___ No	
How many times/week? _____	Ultrasound, heat, TENS, etc.? ___ Yes ___ No	
Had physical therapy?	Did it Help? ___ Yes ___ No	
How many weeks _____		
How many times/week? _____		
Tried Acupuncture	Did it Help? ___ Yes ___ No	
Taken Anti-Inflammatory meds	Did it Help? ___ Yes ___ No	
Taken Pain Medications	Did it Help? ___ Yes ___ No	
Worn a Brace	Did it Help? ___ Yes ___ No	
Taken Time Off Work	Did it Help? ___ Yes ___ No	
Altered your daily activities	Did it Help? ___ Yes ___ No	
Rested	Did it Help? ___ Yes ___ No	
Put ice on your Neck/Back	Did it Help? ___ Yes ___ No	
Put heat on your Neck/Back	Did it Help? ___ Yes ___ No	

What makes your pain worse?

_____ lying down	_____ sitting	_____ sneezing
_____ exercise	_____ standing	_____ other: _____
_____ bending forward	_____ walking	
_____ bending backward	_____ coughing	

What make your pain better?

_____ lying down	_____ manipulation	_____ physical therapy
_____ sitting	_____ exercise	_____ aspirin
_____ standing	_____ prescription pain pills	_____ Tylenol
_____ walking	_____ muscle relaxers	_____ over the counter medications

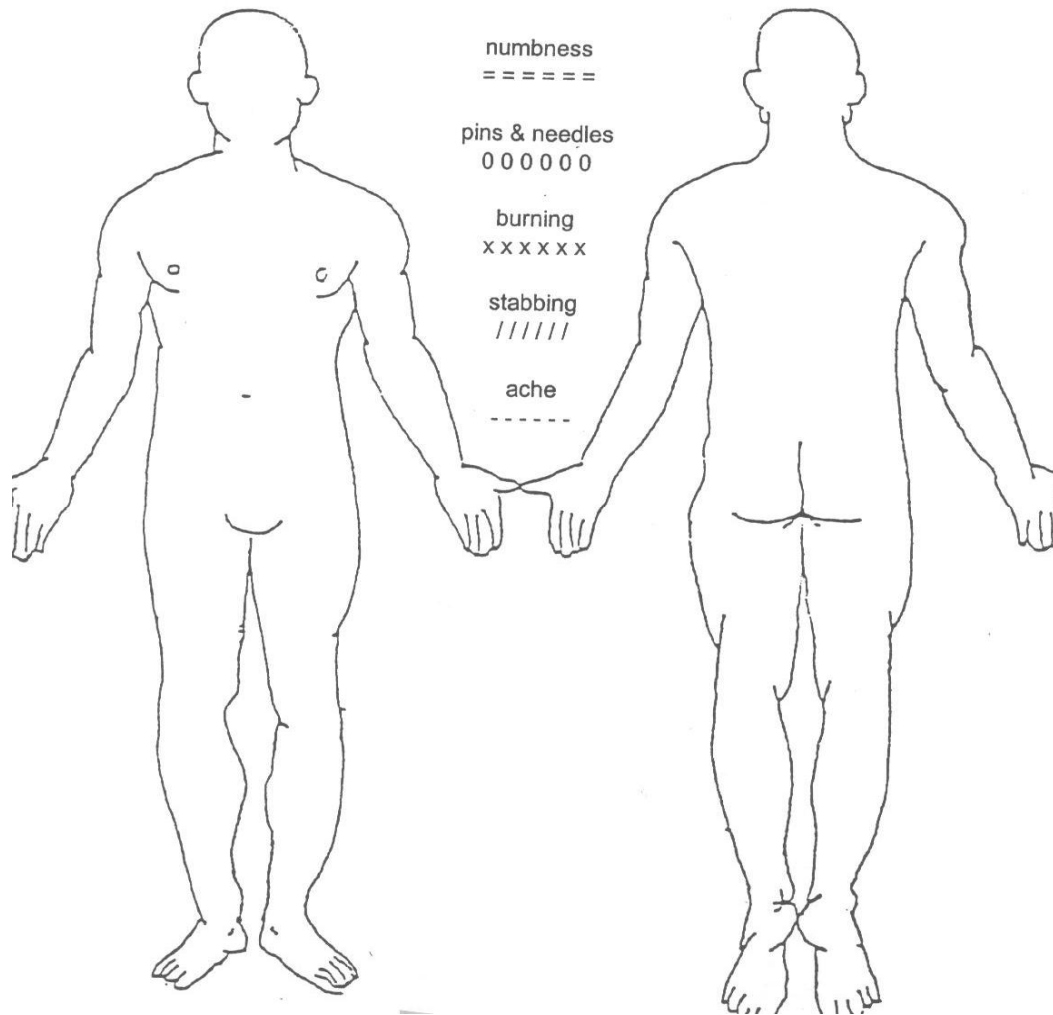
How far can you walk?

_____ blocks (number: _____)	_____ around the house
_____ unlimited	_____ other: _____

Have you ever had back or neck surgery (if so, please describe)? _____

Have You ever been hospitalized for this problem? If so, please describe: _____

Mark these drawings according to where you hurt (if the back of your neck is hurt, mark the drawing on the back of the neck, etc.) If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram. If markings are not applicable, indicate areas of pain in your own words.



Have you had: (check all that apply)

_____ plain x-rays	date:	place:
_____ CAT scan	date:	place:
_____ MRI	date:	place:
_____ myelogram	date:	place:
_____ discogram	date:	place:
_____ EMG	date:	place:
_____ Nerve block	date:	place:
_____ facet block	date:	place:
_____ epidural injection (s)	date:	place: how many?
_____ bone scan	date:	place:
_____ oral steroids	date:	place:
_____ Nerve block	date:	did they help?

MEDICAL HISTORY REVIEW

NAME: _____ AGE: _____ DATE: _____

HEIGHT: _____ WEIGHT: _____

Allergies to medications (list all): _____

Current Medications (list medication, dosage and how often you take it): _____

Review of systems (check all that apply):

CONSTITUTIONAL:

- _____ weight gain
- _____ weight loss
- _____ fever
- _____ chills
- _____ sexual dysfunction

GASTROINTESTINAL:

- _____ abdominal pain
- _____ diarrhea
- _____ constipation
- _____ bowel incontinence

SKIN:

- _____ cancer
- _____ skin

EYES:

- _____ vision sharp
- _____ blurred vision
- _____ double vision

URINARY:

- _____ difficulty urinating
- _____ urinary incontinence
- _____ urgency

ALLERGY:

- _____ seasonal
- _____ tape
- _____ food
- _____ animals
- _____ dust
- _____ other

HEAD/EARS/NOSE/THROAT:

- _____ headache
- _____ nasal drainage
- _____ hearing loss

NEUROLOGICAL:

- _____ seizure
- _____ memory

CARDIOVASCULAR/RESPIRATORY:

- _____ chest pain (angina)
- _____ palpitations
- _____ heart arrhythmia
- _____ shortness of breath

PSYCHIATRIC:

- _____ depression
- _____ manic depression
- _____ other

OTHER PROBLEMS WE SHOULD BE AWARE OF:

Past medical history:

YOU:	Family:	YOU:	Family:	other medical conditions:
				YOU: _____

				Family: _____

Do you smoke? _____ yes _____ no (# packs/day: _____ for _____ years _____ Other forms of tobacco: _____)

Do you drink? _____ yes _____ no (number of drink/week _____)

Please list any other surgeries you have had:

