



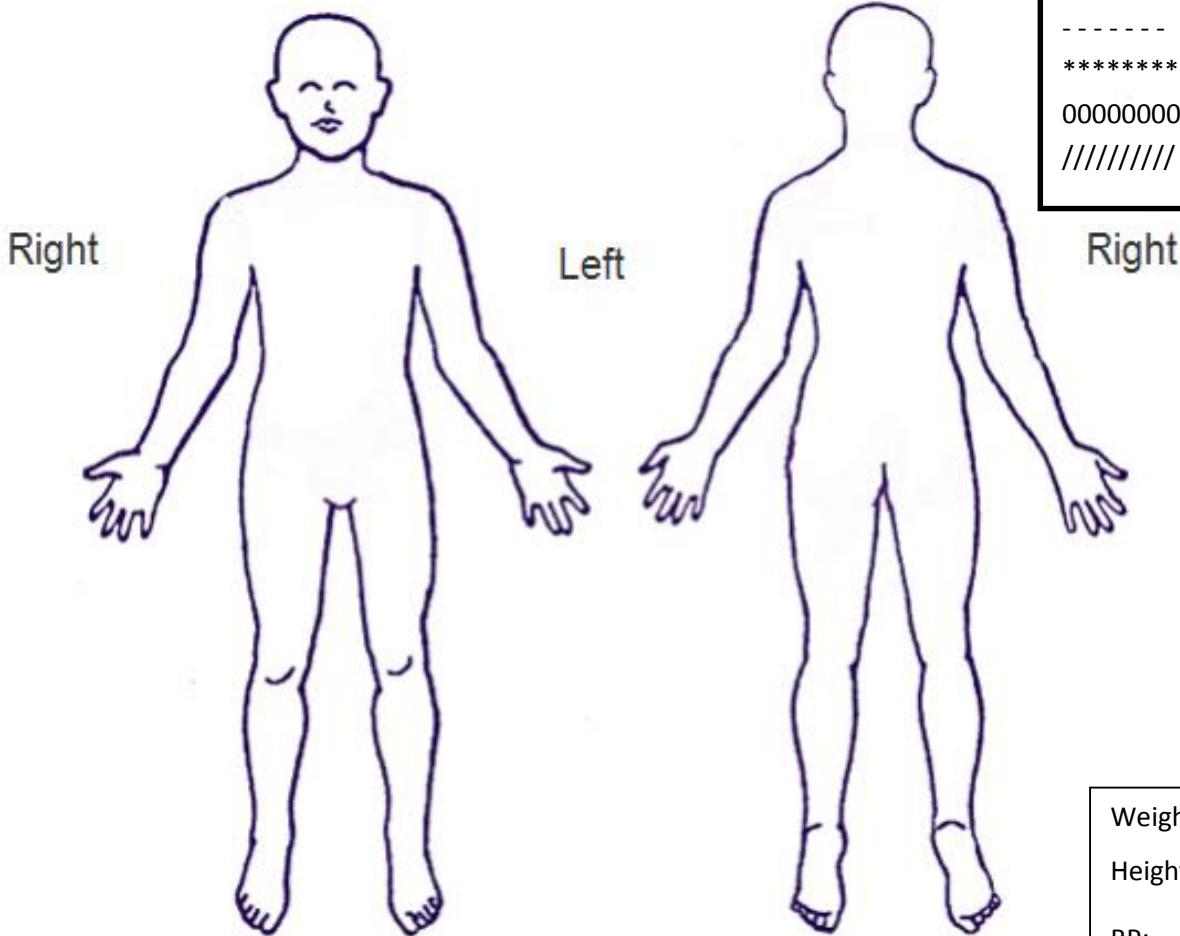
Pain Drawing

Name: _____ Today's Date: _____

How were you referred to the office: _____

Please be sure to fill this out as accurately as possible. This will become part of your permanent medical record and will be used to compare your progress throughout your treatment. Mark the area on your body where you feel the described sensations(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas.

- XXXXXXX Pain (Sharp/ Stabbing)
- Numbness
- ***** Pins and Needles
- 00000000 Ache (Dull)
- ////////// Burning



Weight: _____ lbs.
 Height: ___ ft. ___ inches
 BP: ___/___ Pulse: _____

Visual Analog Scale

Please mark on the pain level that most accurately represents your pain

	NO PAIN											UNBEARABLE PAIN
Today's Pain	0	1	2	3	4	5	6	7	8	9	10	
Worst Pain	0	1	2	3	4	5	6	7	8	9	10	
Best Pain	0	1	2	3	4	5	6	7	8	9	10	



Chief Complaint

Reason for today's visit: _____

History of Present Illness

What is your occupation? _____

When did your symptoms start?: _____

Symptoms (specific problems): _____

Is your current problem the result of an accident? (Please circle) No Yes

Date of Accident	Type (Work, Car, Other)	Description of Injury

Are you currently working? Yes, Full-time Yes, Part-time No N/A
Are you on modified duty? Yes No



What is the **RATIO** of neck pain versus arm pain? (i.e. 80:20)_____

Neck Pain

I have neck pain in the Middle of my neck To the Right To the Left On both sides

Neck Symptoms are worse when Sitting / Driving
 Standing Walking Lying Down

Neck Symptoms are better when: Sitting / Driving
 Standing Walking Lying Down

Do you get headaches? No Yes If yes, please describe them:_____

Arm / Shoulder Symptoms

I have pain in my Right Shoulder/Shoulder Blade Elbow Arm Hand

Left Shoulder/Shoulder Blade Elbow Arm Hand

I have numbness in my Right Shoulder/Shoulder Blade Elbow Arm Hand

Left Shoulder/Shoulder Blade Elbow Arm Hand

I have weakness in my Right Shoulder/Shoulder Blade Elbow Arm Hand

Left Shoulder/Shoulder Blade Elbow Arm Hand

I am Left Handed Right Handed Ambidextrous

Arm Symptoms are worse when Sitting / Driving
 Standing Walking Lying Down

Arm Symptoms are better when: Sitting / Driving
 Standing Walking Lying Down

- I have noticed problems with:
- Gait / Walking / Balance
 - Fine Motor coordination (using buttons, clasps, fine movements)
 - Handwriting is sloppier
 - Clumsiness, dropping things more frequently
 - Bowel or bladder incontinence**



If you tried any of the **treatments** below, please let us know if they are/were helpful?

	Was it helpful?	Comments
Physical Therapy		
Massage Therapy		
Osteopathic Manipulation		
Chiropractic Care		
Bracing		
TENS Unit		
Acupuncture		
Pilates / Yoga		

Have you had a trial of **medications** for this problem? No Yes If yes, please list in the table below

Name	Strength	Formulation	Frequency	How long?	Did it help?

Have you had any **imaging** for this problem?

Date	CT/X-ray/MRI	Where were these done?	Did you Bring them with you?

Have you had pain **injections**?

Date	Physician	Type of Injection	Immediate Relief during the first hour?	How long did the relief last?

Have you had a recent **EMG**? No Yes If yes, who did it and when? _____

Have you ever had **spinal** surgery before? No Yes If yes, please list in the table below

Date	Type of Surgery	Surgeon



Medications

Please fill in the table with medications that you are **currently** taking

Name	Strength	Formulation	Frequency

Past Medical History

Please list any major or significant illnesses and/or injuries (i.e. Diabetes, cancer, heart disease, high blood pressure)

		Date if applicable
1		
2		
3		
4		
5		
6		
7		
8		
9		

Allergies

Please list any allergies to either medications (i.e. Penicillin, sulfa) and/or non-medications (i.e. shellfish, eggs, latex)

Agent	Reaction

Have you had any problems with anesthesia? No Yes, _____



Surgical History/ Hospitalizations

Please list **surgical** history

Date	Type of Surgery

Please list any **hospitalizations** for reasons other than surgery or childbirth (i.e. Pneumonia, heart failure, infection)

Date	Reason for hospitalization

Family History

Please list any significant family illnesses or conditions (i.e. Scoliosis, heart disease, diabetes, stroke). If they are healthy, there is no need to fill in that portion of the form.

Family Members	Status (Healthy/Deceased)	Current Age / Age at Death	Health Conditions
Mother			
Father			
Grandmother (Father's)			
Grandfather (Father's)			
Grandmother (Mother's)			
Grandfather (Mother's)			
Sister / Brother			
Sister / Brother			

Social History

Marital Status: Single Married Widowed

Do you smoke cigarettes? No
 Not now, I quit ___ years ago.
 Yes, I smoke _____ packs of cigarettes a day and have done this for _____ years.

Do you use tobacco products? Yes I use _____

Do you drink alcohol? No, never or rarely
 Yes Daily 1 or more times a week 1 or more times a month

Do you use street drugs? No Yes

Residence House Apartment Assisted Living



Review of Systems

Please fill in the following form. If you have none of the symptoms listed, please leave the box blank.

<p>General/Constitutional</p> <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Weight loss <input type="checkbox"/> Other _____	<p>Gastrointestinal</p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Diarrhea <input type="checkbox"/> Exposure to Hepatitis <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Heartburn / GERD <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Other _____
<p>ENT</p> <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Other _____	<p>Genitourinary</p> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Painful Urination <input type="checkbox"/> Other _____
<p>Endocrine</p> <input type="checkbox"/> Excessive Sweating <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Irregular Menses <input type="checkbox"/> Diabetes <input type="checkbox"/> Other _____	<p>Musculoskeletal</p> <input type="checkbox"/> Broken Bones <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Painful Joints <input type="checkbox"/> Other _____
<p>Respiratory</p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Wheezing <input type="checkbox"/> Other _____	<p>Peripheral Vascular</p> <input type="checkbox"/> Decreased Sensation in extremities / peripheral neuropathy <input type="checkbox"/> Ulceration of feet <input type="checkbox"/> Swelling in feet <input type="checkbox"/> Other _____
<p>Cardiovascular</p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Cyanosis <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Other _____	<p>Neurologic</p> <input type="checkbox"/> Memory Loss <input type="checkbox"/> Seizures <input type="checkbox"/> Tremor <input type="checkbox"/> Previous Brain Injury <input type="checkbox"/> Concussion <input type="checkbox"/> Other _____