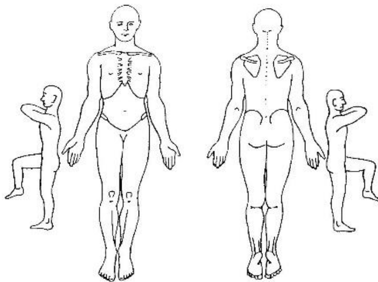
Name____Date_______________
Address____________________________________City___________________Zip_____________
Phone Number____________________Email____
Date of Birth____________ Height___________ Weight____________ Blood Pressure___________
Allergies:____
Occupation, Job Tasks____
Injury onset date:__________ Surgery performed: Yes/NO Surgery date:____________________
Pain location (please specify right or left if applicable) :____________________________________
History of present condition/mechanism of injury: ______________________________________
____
Do you believe that physical activities might make your pain worse? YES NO
Patient goals:____
Have you received treatment for this problem? If so, explain_________________________________
Please list any test performed for this problem (x-ray, labs, ext…)______________________________
For Women: Are you pregnant or think that you may be pregnant? (Circle one) YES NO



Please mark the areas where you feel symptoms on the chart
to the left with the following symbols to describe your symptoms:
↓ Shooting/sharp pain
° Dull/aching pain
III Numbness
= Tingling

Using the 0 to 10 pain scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

A. The worst pain you've had: 0 1 2 3 4 5 6 7 8 9 10

B. The current level of pain you're having- 0 1 2 3 4 5 6 7 8 9 10

C. The level of pain you've had at best- 0 1 2 3 4 5 6 7 8 9 10

When are your symptoms the worst? Morning Afternoon Evening Night During Exercise After Exercise

When are your symptoms the best? Morning Afternoon Evening Night During Exercise After Exercise

Circle the following aggravating factors:
Sitting standing walking going up stairs going down stairs
sitting to standing bending voiding lying down coughing/sneezing

Previous History of Similar Symptoms: YES NO **General health:** GOOD FAIR POOR

Home Health Care: YES NO **Unexplained weight loss:** YES NO

History of falls (2 or more falls with 1 resulting in an injury within the past year): YES NO

MEDICAL HISTORY:

○ No known significant Past Medical History	○ History of Cancer
○ Alzheimer's	○ Huntington's
○ Cardiovascular Disease	○ Immunosuppression
○ Cauda Equina Syndrome	○ Lupus
○ Cerebral Vascular Accident	○ Muscular Dystrophy
○ Current Infection	○ Obesity
○ Diabetes Mellitus Type I	○ Osteoarthritis
○ Diabetes Mellitus Type II	○ Parkinson's
○ Fibromyalgia	○ Rheumatoid Arthritis
○ Fracture or Suspected Fracture	○ Traumatic Brain Injury
○ High Blood Pressure	○ Other-

If you use tobacco, drink alcohol or caffeine, please list how often and quantity.
____

Please list any surgeries or cause of hospitalization you may have had, including dates.
____
____
____

Current Medications with Dosages:************
____
____
____

1. Are you basically satisfied with your life? Yes No
2. Have you dropped many of your activities and interests? Yes No
3. Do you feel that your life is empty? Yes No
4. Do you often get bored? Yes No
5. Are you in good spirits most of the time? Yes No
6. Are you afraid that something bad is going to happen to you? Yes No
7. Do you feel happy most of the time? Yes No
8. Do you often feel helpless? Yes No
9. Do you prefer to stay at home, rather than going out and doing new things? Yes No
10. Do you feel you have more problems with memory than most? Yes No
11. Do you think it is wonderful to be alive now? Yes No
12. Do you feel pretty worthless the way you are now? Yes No
13. Do you feel full of energy? Yes No
14. Do you feel that your situation is hopeless? Yes No
15. Do you think that most people are better off than you are? Yes No
16. Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

H:__________W:_________