Name_____Date_____

Address_____City_____Zip_____

Phone Number_____ Email_____

How did you hear about us? _____

Date of Birth_____ Height_____ Weight_____ Blood Pressure_____

Hand Preference: R or L Allergies:_____

Occupation, Job Tasks_____

Recreational Activities_____

Personal Goals for Activities_____

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches).

_____

_____

Have you had 2 or more falls with 1 resulting in an injury within the past year? (Circle one) YES NO

For Women: Are you pregnant or think that you may be pregnant? (Circle one) YES NO

When are your symptoms the worst? (Circle one)

Morning Afternoon Evening Night During Exercise After Exercise

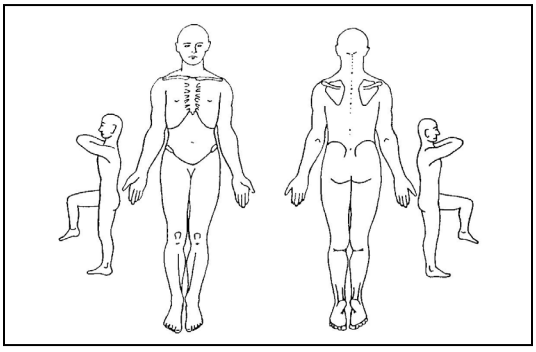
When are your symptoms the best? (Circle One) Morning Afternoon Evening Night During Exercise After Exercise

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

A. Your current level of pain while completing this survey- 0 1 2 3 4 5 6 7 8 9 10

B. The least pain you've had in the past 24 hours- 0 1 2 3 4 5 6 7 8 9 10

C. The worst pain you've had in the past 24 hours- 0 1 2 3 4 5 6 7 8 9 10



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

Have you RECENTLY noted any of the following? (Check all that apply)

- ○ Fatigue
- ○ Fever/chills/sweats
- ○ Nausea/vomiting/loss of appetite
- ○ Weight loss/gain
- ○ Falls or difficulty maintaining balance
- ○ Changes in bowel or bladder function
- ○ Numbness or tingling
- ○ Muscle weakness
- ○ Dizziness/lightheadedness
- ○ Heartburn/indigestion
- ○ Difficulty breathing
- ○ Vision or hearing loss
- ○ Constipation
- ○ Diarrhea
- ○ Shortness of breath
- ○ Fainting
- ○ Cough
- ○ Headaches

Have you EVER been diagnosed with any of the following conditions? (Check all that apply)

- ○ Cancer
- ○ Heart Problems
- ○ High blood pressure
- ○ Chest pain/angina
- ○ Circulation problems
- ○ Blood clots
- ○ Bladder/urinary tract infection
- ○ Sexually transmitted disease/HIV
- ○ Chemical dependency (alcoholism)
- ○ Depression
- ○ Lung problems
- ○ Asthma
- ○ Rheumatoid arthritis
- ○ Other arthritic conditions
- ○ Eye problem/infection
- ○ Kidney problem/infection
- ○ Bone or joint infection
- ○ Pelvic inflammatory disease
- ○ Thyroid problems
- ○ Diabetes
- ○ Osteoporosis
- ○ Multiple sclerosis
- ○ Epilepsy
- ○ Stroke
- ○ Liver problems
- ○ Hepatitis
- ○ Pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions? (Check all that apply)

- ○ Cancer
- ○ Heart problems
- ○ High blood pressure
- ○ Diabetes
- ○ Stroke
- ○ Depression
- ○ Thyroid problems
- ○ Blood clots
- ○ Tuberculosis

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.

_____

_____

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

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

Is this something with which you would like help? YES NO or YES, but not today.

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Do you believe that physical activities might make your pain worse? YES NO

What date did your current symptoms start?_____
What do you think caused your symptoms? _____
Have you received treatment for this problem? IF so, explain. _____
Please list any test performed for this problem (x-ray, labs, ext…) _____