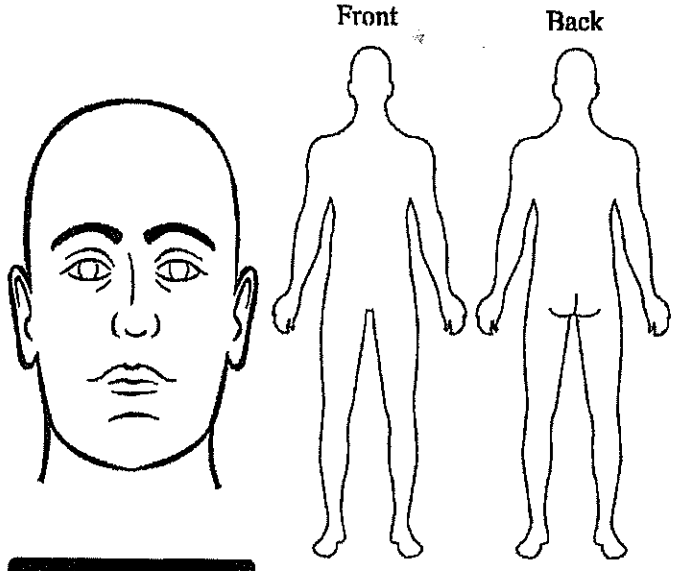

SYMBOLS

Ache: MMM	**Tenderness:** Z Z Z
Burning: - - - -	**Pins & Needles:** • • •
Spasm: X X X	**Numbness:** 0 0 0
Radiating Pain: ↓ ↑	**Stabbing Pain:** / / /

Using the symbols above, please indicate the type & location of your pain or symptoms

History of Illness

Location of Pain or Symptoms: _____

Current Pain: No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain
Min. Pain Level: No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain
Max. Pain Level: No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Is Pain/Symptoms: O Constant O Improving O Not Changing
O Intermittent O Worsening

Pain is worst at: O AM O PM

Pain interferes with sleeping: O Yes O No O Sometimes

When & how did it start?

_____

What makes your pain/symptoms worse?

_____

What makes your pain/symptoms better?

_____

Does your condition interfere with any of the following:
O Mobility
O Carrying, moving, or handling Objects
O Changing or maintaining body position
O Self Care (Bathing, changing clothes, etc.)
Explain if other _____

I can not do the following daily activities of normal living:
1. _____ 3. _____
2. _____ 4. _____
5. _____ 6. _____

Have you had any of the following tests?
O XRAY O MRI O CT Scan O EMG/NCS
Where was the test done? _____

Surgeries/hospitalizations including dates (if known):

_____

_____

Injuries with approx. dates (i.e., fractures, dislocations, sprains):

_____

_____

Allergies:

_____

Medications (over-the-counter, prescription, herbal, vitamin/mineral/dietary (nutritional supplements)

Name	Route of Administration	Dosage	Frequency taken

***I agree to notify clinical staff of any changes of dosage, frequency, or medicines as soon as possible _____ (Patient Initials)**

What are your treatment goals?

_____

_____

_____

Patient Name (Printed): _____

Past Medical History

Have you EVER been diagnosed with the following?

YES	NO (check one)	
O	O	Diabetes
O	O	High blood pressure
O	O	Asthma
O	O	Heart Attack – Date/s _____
O	O	Other Heart Trouble (Type)_____
O	O	Stroke – Date/s _____
O	O	Emphysema
O	O	Osteoporosis
O	O	Arthritis
O	O	Seizures/Epilepsy
O	O	Fibromyalgia
O	O	Cancer – Type _____ Date/s _____
O	O	HIV/AIDS/Hepatitis/Other _____
O	O	Back Injury
O	O	Fracture – Type _____ Date/s _____
O	O	Respiratory Problems (explain)_____
O	O	Headaches
O	O	Muscular Dystrophy
O	O	Polio
O	O	TMJ Disorder
O	O	Stomach Ulcers
O	O	Chemical Dependency (alcoholism, legal/illegal drugs)
O	O	Thyroid Problems (hypo- or hyper-)
O	O	Multiple Sclerosis
O	O	Rheumatoid Arthritis
O	O	Depression, Anxiety, Bipolar Disorder, Schizophrenia
O	O	Kidney Disease (Type):_____
O	O	Blood Clots
O	O	Other _____

Do you live alone? O Yes O No

Are there steps in/around your home/work? O Yes O No
If yes, how many? _____
Does your home/work have ramp accessibility? O Yes O No

In a typical day, how many hours are you sitting?
_____

In a typical day, how many hours are you standing?
_____

Exercise:
O Sedentary (no exercise)
O Mild Exercise (climb stairs, walk 3 blocks, golf)
O Occasional Exercise (less than 4x/week for 30 min.)
O Regular vigorous exercise (4x/week for 30 min.)

Caffeine:
O Non-drinker
O Coffee: _____ cups/day
O Tea: _____ cups/day
O Soda: _____ cups/day

Alcoholic Beverages:
O Non-drinker
O _____ days per week (average)
O _____ drinks per sitting (average)

Tobacco:
O Non-user
O _____ years used
O Former Use (year quite: _____)

Type of Tobacco:
O Cigarettes: _____ per day
O Pipe: _____ per day
O Chew: _____ per day
O Cigar: _____ per day

Have you recently noticed any of the following?

YES	NO	(check one)	YES	NO	
O	O	Fatigue or malaise	O	O	Difficulty swallowing
O	O	Unexplained weight loss/gain (circle one)	O	O	Skin rash
O	O	Fever/chills/sweats	O	O	Regular cough (how long _____)
O	O	Nausea/vomiting	O	O	Arm/leg swelling
O	O	Dizziness/lightheadedness	O	O	Heart racing in your chest
O	O	Tingling or numbness	O	O	Heartburn/indigestion
O	O	Weakness	O	O	Post-menopause
O	O	Change in cognitive abilities	O	O	Stress at home or work
O	O	Constipation/diarrhea (circle one)	O	O	Problems sleeping
O	O	Blood in the stools	O	O	Sexual difficulties
O	O	Urinary incontinence	O	O	Night sweats
O	O	Problems urinating (pain, starting, stopping, etc.)	O	O	Hearing problems
O	O	Blood in the urine	O	O	Joint/muscle swelling
O	O	Change in appetite	O	O	Easy bruising
O	O	Change in vision	O	O	Excessive bleeding
			O	O	Difficulty breathing

Patient Name (Printed): _____