Name _____ Date _____

Occupation _____ Age _____

1 - For what condition / symptoms are you being seen at this time?

_____

_____

_____

2 - When did it start (give approximate date) ? _____

3 - How did it start? (If accident or injury, please describe the incident). _____

_____

_____

4 - Please give a step by step history of the progression of symptoms from onset to the present. When possible, give approximate dates of important changes or developments.

_____

_____

_____

5 - Do you have back pain? _____

6 - Do you have leg pain? _____
If so, right, left or both? _____
If both, which side is worse? _____

7 - Do you have neck pain? _____

8 - Do you have arm or shoulder pain? _____
If so, right, left or both? _____
Which side is worse? _____

9 - Please describe your pain, including activities which help or make it worse. _____

_____

	Yes	No
Coughing	( )	( )
Bending	( )	( )
Lifting	( )	( )
Sitting / Driving	( )	( )
Standing	( )	( )

10 - Do you have numbness or tingling? _____ Where? _____

_____

11 - Do you have weakness? _____ Where? _____

_____

12 - Do you have any bladder control problems? _____

13 - Do you have any bowel control difficulties? _____

14 - Employer _____
What do you do? _____
How does this affect your back? _____
What activities can you not do that your job requires you to do? _____
_____
_____

15 - Have you ever been in a hospital for back, leg, neck, or arm pain? _____
Dates _____

16 - Have you ever had a myelogram (X-ray of the spine with dye injection)? _____
Dates _____ Who ordered it? _____

18 - Have you ever had an MRI? _____ Dates _____
Who ordered it? _____

19 - Have you ever had an EMG? _____ Dates _____

20 - Do you exercise on a regular basis? _____

21 - What is your weight? _____

22 - What other doctors or chiropractors have you seen for this condition? _____
_____
When _____
Where? _____

23 - Have you ever had surgery on your back or neck? _____
Dates and type of surgery done? _____
_____
_____
_____

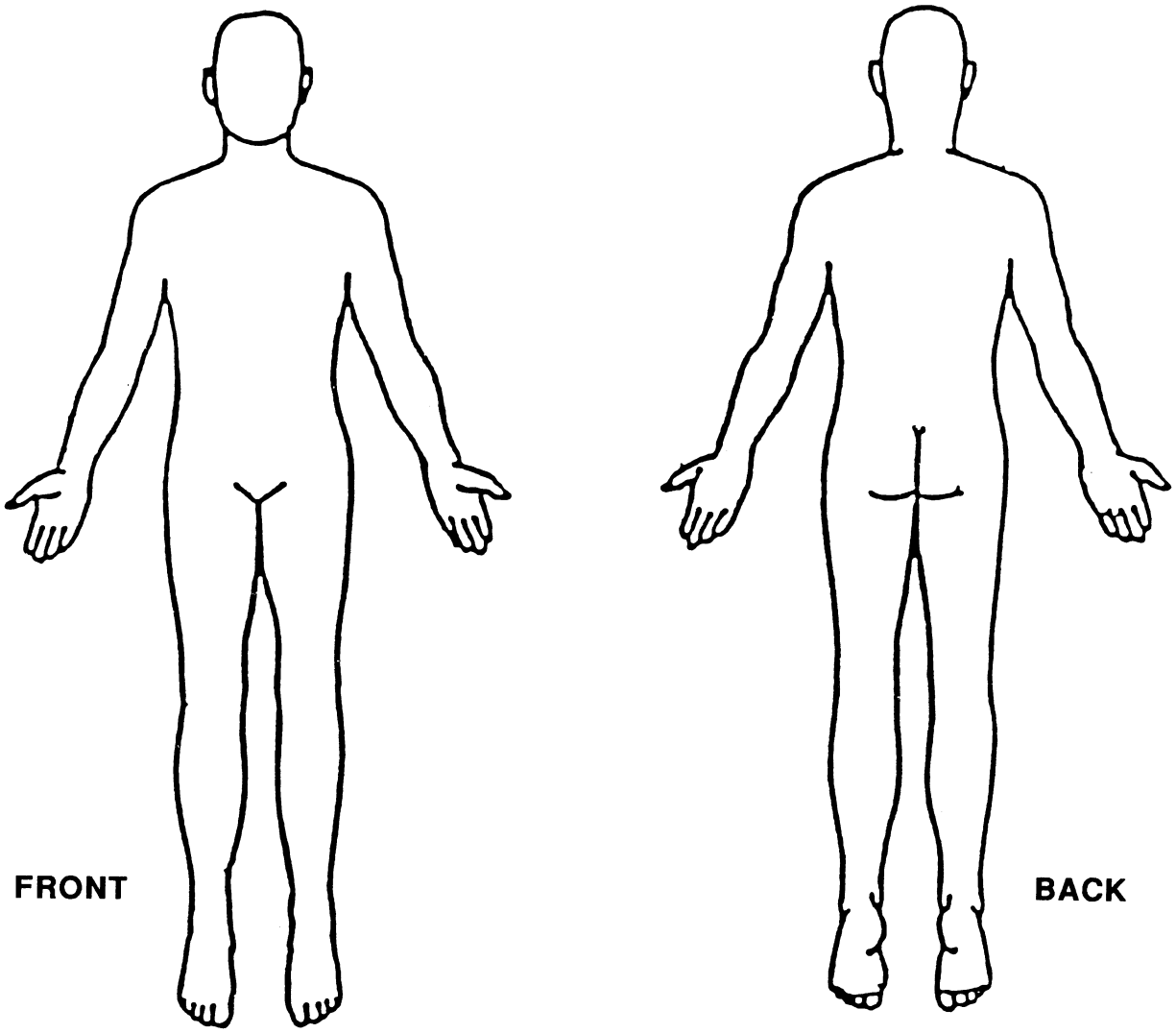
24 - What treatments have you had?

	Where	When
Chiropractic:		
Physical Therapy:		
Pain Management:		

25 - Please list medications you have taken for pain or spasm during the past year, and include dose and number taken per day?
_____
_____
_____
_____

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Include all affected areas.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING
A A A A	X X X X	O O O O	/ / / /	= = = =
A A A A	X X X X	O O O O	/ / / /	= = = =



How bad is your pain now? (mark with an X)

1 (least) — 5 — 10 (The most)

How bad is your pain at its worst?

1 (least) — 5 — 10 (The most)