

5. How did your pain start? (Please check (x) all that apply to you.) *No apparent cause*
 Suddenly Gradually Bending Lifting Twisting Pushing Pulling After a fall

6. Please describe how your pain started: _____

7. Have you been hospitalized or seen in the Emergency Room for your pain? no yes
If yes, when/where? _____

8. What activities make your pain worse? (Please check (x) all that apply to you.) *None*
 Lying Standing Exercise (during) Bending Forward Twisting
 Sitting Walking Exercise (after) Bending Backward Coughing/Sneezing
 Early Morning End of day Other _____

9. What reduces your pain? (Please check (x) all that apply to you.) *None*
 Lying Standing Bending Forward Exercise Heat/Cold Physical Therapy
 Sitting Walking Bending Backward Pain Pills Massage Chiropractic Treatment
 Rest Other _____

10. What types of treatment have you had? (Please check (x) all that apply to you.) *None*
 Physical Therapy Epidural Steroid Injection(s) Trigger Point Injections
 Facet Injection(s) Pool Therapy Chiropractic Treatment
 Other _____

11. Review of systems
Please check (x) all problems that apply to you. *None*
 Numbness/tingling of arms or legs Weakness of arms or legs Night pain/difficulty sleeping
 Bladder/bowel Sexual difficulties Chest pain/short of breath
 Psychiatric/emotional Endocrine/hormonal Fever, chills, or weight loss
 Difficulty w/hands or buttons Blurry vision/headaches Skin rashes
 Other difficulties-what kind? _____

12. Have you had any of the following diagnostic studies?	No	Yes	Date
Diagnostic X-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT (computed tomography) scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI (magnetic resonance image)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMG (electromyogram)/NCV (nerve conduction velocity)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

13. Have you had surgery for this pain or similar pain? no yes
If yes, describe what type of surgery you had, when and where performed, and the name of the surgeon. _____



Past Medical History

Please check (x) the box next to any illnesses or problems that apply to you. None

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Liver disease/hepatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers/Reflux |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Skin rashes/lesions | <input type="checkbox"/> Epilepsy/seizures |
| <input type="checkbox"/> Bleeding/bruising problems | <input type="checkbox"/> Asthma/emphysema | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis-what type? _____ |
| <input type="checkbox"/> Other medical problems-what kind? _____ | | |

Past Surgical History

Please check (x) the box next to any surgical procedures that you have had. None

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Lumbar spine/low back | <input type="checkbox"/> Lung | <input type="checkbox"/> Stomach | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Cervical spine/neck | <input type="checkbox"/> Heart | <input type="checkbox"/> Appendix | <input type="checkbox"/> Uterus/Ovaries/Gyn |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Liver | <input type="checkbox"/> Bowel/Hemorrhoid | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Kidney | <input type="checkbox"/> Hernia | <input type="checkbox"/> Extremities/arms or legs |
| <input type="checkbox"/> Tonsils | <input type="checkbox"/> Other surgeries-what kind? _____ | | |

Allergies

Please check (x) the box next to any allergies that apply to you. None Known

- | | | |
|--|--------------------------------|---------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Other antibiotics or medications, foods, or dyes: _____ | | |

Do you have difficulty taking anti-inflammatory medications? no yes don't know

Medications Currently Taking

Please list name of drug, dosage, and how often taken. None

_____	_____
_____	_____
_____	_____
_____	_____

Family History

Please check (x) the box next to any disease diagnosed in your blood relatives.

- | | | |
|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Other: _____ |

Social History

Please check (x) all that apply to you.

Tobacco use: no yes if yes, packs per day _____ and years of use _____

Alcohol use: no yes if yes, amount per week _____

Non-prescribed medications or recreational drugs: None _____

Work Status: Are you Employed Unemployed Disabled Retired?

What is your occupation? _____

Is this the same occupation you had before your injury? yes no n/a

If no, what was your previous occupation? _____

Are you still working? yes no n/a If no, what was last day on the job? _____

If working, are you at full duty or light duty?