

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                          | Cardiac stent                   |   |   |
| <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?