PATIENT INFORMATION			
Patient Name:		Date:	
Date of Birth:	Gender: Male Female	Height:	Weight:

CURRENT MEDICATIONS		
MEDICATION	DOSAGE	TIMES PER DAY
PLEASE LIST ANY KNOWN ALLERGIES (i.e. food, medication)		
Are you currently taking anti-coagulant/blood thinner medication?	Yes	No
Will you be requesting pain medication at today's visit?	Yes	No

FAMILY HISTORY			
Please mark which blood relative each condition applies to by using the following: (F) Father (M) Mother (S) Sibling (PG) Paternal Grandparent (MG) Maternal Grandparent (D) Distant Relative			
Arthritis	F M S PG MG D	Diabetes	F M S PG MG D
Asthma	F M S PG MG D	Nerve Disorder	F M S PG MG D
Hepatitis	F M S PG MG D	Heart Disease	F M S PG MG D
Bleeding Tendency	F M S PG MG D	Stroke	F M S PG MG D
High Blood Pressure	F M S PG MG D	Gallbladder Disease	F M S PG MG D
Kidney Disorder	F M S PG MG D	Mental Disorder	F M S PG MG D
Cancer	F M S PG MG D	Lung Disease	F M S PG MG D
Other:		F M S PG MG D	

SOCIAL HISTORY			
Alcohol Use	Yes No	Amount/Week:	
Tobacco Use/Smoking	Current Smoker: Yes No	Past Smoker: Yes No	Amount/Day:
How long have you been smoking?			
History of Overdose	Yes No	Approximate Date of Overdose:	Medication Involved:

Illicit Drug Use/Abuse	Current Use/Abuse: Yes No	Past Use/Abuse: Yes No	When did you quit?
Duration of use/abuse of illicit drugs?		Drug Involved: Cocaine Heroin Methamphetamine Alcohol Marijuana Other: _____	

PAIN QUESTIONNAIRE (Please CHECK ALL THAT APPLY)			
WHICH HAND DO YOU USE?	□ LEFT HAND	□ RIGHT HAND	□ AMBIDEXTROUS (uses both left and right hand)
LOCATION (Where is the pain?)	□ LEFT	□ RIGHT	□ BILATERAL (both left & right)
	□ ANTERIOR (Front)	□ POSTERIOR (back)	□ MEDIAL (middle of the body)
	□ LATERAL	□ DEEP (inward)	□ SUPERFICIAL (on the surface)

QUALITY	□ ACHING	□ BURNING	□ GNAWING	□ STABBING	□ THROBBING	□ SHARP
	□ DULL	□ SUPERFICIAL	□ DEEP	□ OCCASIONAL	□ FREQUENT	□ CONSTANT
	□ WORSENING		□ IMPROVING		□ NO CHANGE	

SEVERITY	□ NO PAIN	□ MILD	□ MODERATE	□ SEVERE
	PAIN LEVEL /10		WORST PAIN /10	
DURATION		DATE OF ONSET: DAYS WEEKS MONTHS YEARS		
TIMING (When do you have pain?)	□ CANNOT IDENTIFY	□ ACUTE	□ CHRONIC	□ ABRUPT
	□ GRADUAL	□ MORNING	□ DAYTIME	□ NIGHTTIME
	□ RECURRENT	□ RARE	□ OCCASIONAL	□ INTERMITTENT EPISODES LASTING

CONTEXT (What caused the pain?)	□ CANNOT IDENTIFY	□ FALL	□ BENDING	□LIFTING
	□ TWISTING	□ SPORTS INJURY	□ WORK INJURY	□MVA
	□ ASSAULT	□ OVERUSE	□ ATRAUMATIC	□LACERATION

ALLEVIATING FACTORS (What helps the pain?)	□ NOTHING HELPS	□ SITTING	□ STANDING	□ LYING DOWN	□ POSITION CHANGE
	□ HEAT	□ ICE	□ REST		□ ELEVATION EXERCISE
	□ LIMITED WEIGHT BEARING	□ PT/OT	□CHIROPRACTIC CARE		□ ESI
	□ OTC MEDICATION	□ NARCOTICS	□ NSAIDs		□ CORTISONE INJECTION
	□ VICOSUPPLEMENT INJECTION	□ ORTHOTICS	□ PREVIOUS SURGERY	□ BRACE	□ SLING

AGGRAVATING FACTORS (What makes the pain worse?)	□ CANNOT INDENTIFY	□ SITTING	□ STANDING	□ LYING DOWN	□ WALKING LIFTING
	□ CARRYING	□ TWISTING	□ PUSHING/ PULLING GRIPPING	□ GRASPNG	□ SQUEEZING
	□ THROWING	□ ROM	□ WEIGHTBEARING EXERCISE	□ PREVIOUS SURGERY	
	□ COMPUTER USE	□ CHANGING CLOTHES	□ GETTING OUT OF BED		
	□ GOING FROM SIT TO STAND	□ MORNING	□ DAYTIME	□ NIGHTTIME	
	□ COLD WEATHER		□ DAMP WEATHER		

ASSOCIATED SYMPTIONS (Because of the pain these things happen.)	☐ WEAKNESS	☐ NUMBNESS	☐ TINGLING	☐ SWELLING	☐ REDNESS
	☐ WARMTH	☐ ECCHYMOSIS	☐ CATCHING/ LOCKING	☐ POPPING/ CLICKING	
	☐ BUCKLING	☐ GRINDING	☐ INSTABILITY	☐ RADIATION DOWN ARM	
	☐ DRAINAGE	☐ FEVER	☐ CHILLS	☐ WEIGHT LOSS	
		☐ CHANGE IN BOWEL/BLADDER HABITS			

Pain Rating (0-10)	Without Pain Medication:	With Pain Medication:
Are you able work?	Yes	No
Are you able to care for yourself?	Yes	No

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PREVIOUS DIAGNOSTIC TESTING/IMAGING			
TYPE	DATE(S)	TYPE	DATE(S)
MRI		X-ray	
CT Scan		EMG/NCV	

PREVIOUS TREATMENTS & RESULTS			
TYPE	DATE(S)	DURATION	BENEFICIAL
Physical Therapy			Yes No
Chiropractic Therapy			Yes No
Aquatic Therapy			Yes No

TYPE	DATE(S)	% OF RELIEF
Epidural Injection		
Facet Injection		
Medial Branch Block		
Radiofrequency Ablation		

SURGERIES/PROCEDURES		HOSPITALIZATIONS	
TYPE	DATE	REASON	DATE

Please circle all that apply (current and past)

General/Constitutional

Fever night sweats Weight gain (lbs) Weight loss (lbs) exercise intolerance sedation lethargy chills malaise

Ophthalmologic

wears glasses/contact lenses dry eyes irritation vision change eye disease/injury

ENT

Ears: difficulty hearing ear pain ringing in the ears
Nose: frequent nosebleeds nose problems sinus problems sinusitis
Mouth/Throat: sore throat bleeding gums snoring dry mouth oral abnormalities mouth ulcers teeth abnormalities mouth breathing

Cardiovascular

chest pain on exertion arm pain on exertion shortness of breath when walking ankle swelling shortness of breath when lying down palpitations known heart murmur light-headed standing

Respiratory

Cough wheezing shortness of breath coughing up blood sleep apnea

Gastrointestinal

abdominal pain nausea vomiting constipation change in appetite black or tarry stools frequent diarrhea vomiting blood dyspepsia GERD

Genitourinary

urinary loss of control difficulty urinating increased urinary frequency hematuria incomplete emptying

Musculoskeletal

muscle aches muscle weakness arthralgias/joint pain back pain neck pain swelling in the extremities difficulty walking cramps osteoporosis fractures

Skin

abnormal mole jaundice rash itching dry skin growths/lesions laceration non-healing areas changes in hair/nails psoriasis change in skin color breast lump

Neurologic

loss of consciousness weakness numbness seizures dizziness paralysis frequent or severe headaches migraines restless legs tremor gait dysfunction

Psychiatric

Depression sleep disturbances feeling unsafe in relationship restless sleep alcohol abuse anxiety hallucinations suicidal thoughts mood swings memory loss agitation dementia delirium

Endocrine

Fatigue increased thirst hair losss increased hair growth cold intolerance

Hematologic/Lymphatic

swollen glands easy bruising excessive bleeding anemia phlebitis

Allergy/Immunologic

Runny nose sinus pressure itching hives frequent sneezing

Other: