

Date of Evaluation ____/____/____

Name (first/middle initial/last) _____ Age ____ D.O.B. ____/____/____

Referring Physician _____ Family Physician _____

Occupation _____ Work related? Yes No Auto related? Yes, State ____ No

Leisure Activities _____

How did you hear about us? Physician Family Friend Radio Advertisement Other _____

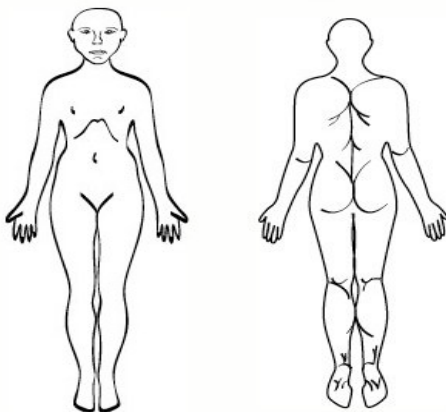
1. What problems or concerns would you like addressed? Explain: _____

2. When did your problem develop? (exact date) ____/____/____

3. How did your problem begin? _____

4. Since your problem began, is it? Improving Staying the same Worsening

5. Please note on the diagram where you're experiencing pain (using the appropriate letters):



T = Tingling
D = Dull
S = Sharp
N = Numbness
B = Burning
R = Radiating
A = Ache

6. Is your pain?
 Constant Intermittent

7. Express your pain on a scale of 0-10 (10 being extreme):
_____ At present _____ At best _____ At worst

8. Are there any activities or positions that significantly worsen your symptoms?

- Sitting Standing Walking Lifting Lying down Ice Heat Coughing/Sneezing
- Bending Bowel or bladder movements Other _____

9. Are there any activities or positions that significantly improve your symptoms?

- Sitting Standing Walking Lifting Lying down Ice Heat Pain medications
- Bending Other _____

10. What part of the day do you feel best? _____ Worst? _____

11. Is sleep disturbed due to your pain? Yes No

(over)

12. Are you currently receiving the following treatment with another provider?

- Physical Therapy
- Chiropractic
- Massage
- Home Healthcare Services
- Skilled Nursing Facility Services

13. Have you had prior treatment(s) for this condition?

- Physical Therapy
- Chiropractic
- Injections
- Massage
- Surgery
- Acupuncture
- Other _____

14. Recent diagnostic tests? X-ray CT Scan MRI EMG Bone Scan Other _____

15. Please list all medications you are currently taking: _____

16. Have you ever had any of the following? (Please check all that apply.)

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart problems /Heart attack | <input type="checkbox"/> Nausea | <input type="checkbox"/> Smoking
<input type="checkbox"/> past <input type="checkbox"/> present |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Pregnancy
<input type="checkbox"/> past <input type="checkbox"/> present | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Rheumatoid | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Liver/Gallbladder | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fever | <input type="checkbox"/> Major trauma | <input type="checkbox"/> Seizures | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Head injury | <input type="checkbox"/> Metal implants | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Headaches | | | |

Please explain any checked items above and add others not listed: _____

17. Past surgical history: _____

DX1 _____ DX2 _____ DX3 _____