

Date: [REDACTED]

Occupation: [REDACTED]

1. Please describe the problem that brings you here today. What caused your problem?  
 [REDACTED]

2. Shade in on the body chart where you are having pain, numbness (can't feel), tingling, weakness, or other symptoms.

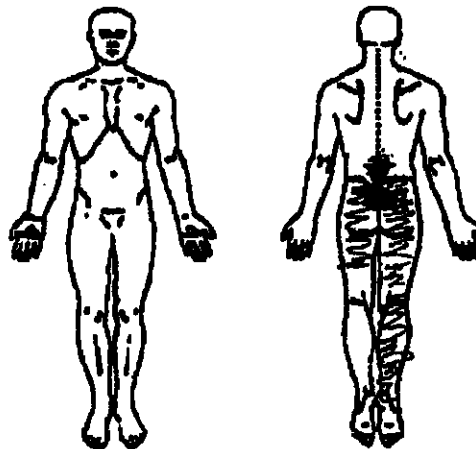
3. Do you have any symptoms of:

PAIN: Where? [REDACTED]  
 Always there  Comes and goes

NUMBNESS: Where? [REDACTED]  
 Always there  Comes and goes

TINGLING: Where? [REDACTED]  
 Always there  Comes and goes

WEAKNESS: Where? [REDACTED]  
 Always there  Comes and goes



4. When did these symptoms first appear?  
 [REDACTED]

5. When are your symptoms worse?

MORNING  AFTERNOON  EVENING  NIGHT  SLEEP DISTURBED

6. If you have pain / symptoms in more than one area: Which area is the worst?  
 [REDACTED]

7. What particularly makes your symptoms worse?

COUGH  SITTING: How many minutes? [REDACTED]  STANDING: How many minutes? [REDACTED]  
 SNEEZE  BENDING  WALKING: How many minutes? [REDACTED]  
 LIFTING  HEAD MOVEMENTS  ARM MOVEMENTS  
 OTHER: \_\_\_\_\_

8. What makes your symptoms feel better?

STANDING: How many minutes? \_\_\_\_\_  SITTING: How many minutes? \_\_\_\_\_  
 WALKING: How many minutes? \_\_\_\_\_  BENDING FORWARD  
 LYING DOWN ON MY:  STOMACH  BACK  SIDE  
 OTHER: \_\_\_\_\_

OVER →



9. Have you ever had these same symptoms in the past? If so when? \_\_\_\_\_

10. Is your problem:  Getting better  Staying the same  Getting worse

11. Are you currently off of work because of your problem?  YES  NO If so, how long? \_\_\_\_\_

12. Is there litigation (legal action) involved?  YES  NO

13. What medications are you currently taking? (Please list ALL or provide copy of medication list):  
\_\_\_\_\_

14. What treatments have you had so far for this problem?

MEDICATION:

- Motrin/Naprosyn/Clinoril  Robaxin  Soma  Tylenol  Elavil
- Flexeril  Neurontin  Vioxx/Celebrex  Vicodin  Percocet (Roxicet)
- Prednisone (steroid) taper When? \_\_\_\_\_  OTHER \_\_\_\_\_

Have any of the medications helped? If so, which ones? \_\_\_\_\_

INJECTIONS: When? \_\_\_\_\_ Helped?  YES  NO

SURGERY: What? \_\_\_\_\_ When? \_\_\_\_\_ Helped?  YES  NO

PHYSICAL THERAPY: How many treatments \_\_\_\_\_ When? \_\_\_\_\_ Helped?  YES  NO

Treatment:  Exercise  Heat  Ultrasound  Traction  Hands on therapy  Electric Stimulation

CHIROPRACTIC: How many treatments \_\_\_\_\_ When? \_\_\_\_\_ Helped?  YES  NO

OTHER \_\_\_\_\_

15. Do you do any regular exercise? If so, what? \_\_\_\_\_

16. What are your Expectations/Goals for Physical Medicine? \_\_\_\_\_

17. Have you had any diagnostic tests done for this problem?

- XRAY: When? \_\_\_\_\_  MYELOGRAM: When? \_\_\_\_\_
- CT Scan: When? \_\_\_\_\_  MRI: When? \_\_\_\_\_  OTHER: When? \_\_\_\_\_

18. Past Medical History

- Broken bones: Which bone? \_\_\_\_\_  High Blood Pressure
- Motor vehicle accident: When? \_\_\_\_\_  Asthma/Lung problems
- Other injuries? What? \_\_\_\_\_  Diabetes
- Cancer: What? \_\_\_\_\_ When? \_\_\_\_\_ Current status? \_\_\_\_\_
- Chemotherapy  Radiation  Surgery
- Heart problems: What? \_\_\_\_\_ When? \_\_\_\_\_
- Pacemaker  Vascular disease (poor blood flow)
- Depression  Unexplained weight loss
- Stroke  Long term steroid use ( more than 3 months)

19. Past Surgical History

- Spine Surgery: What? \_\_\_\_\_
- Joint Replacement, What? \_\_\_\_\_
- Other Surgery: What? \_\_\_\_\_