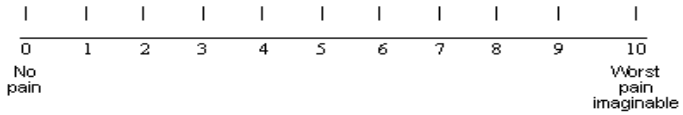
Name:_____ **Date:** _____

Patient Medical Information

Occupation _____

Leisure Activities _____

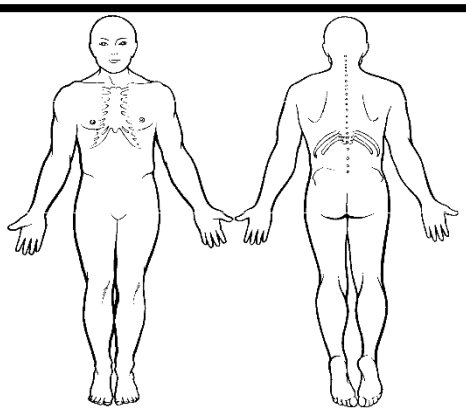
Use the scale below to answer the next 3 questions:



Your **current** level of pain while completing this survey __/10

The **least** your pain has been in the past 48 hours __/10

The **worst** your pain has been in the past 48 hours ___/10



Please mark the location(s) on the diagram where you are experiencing the problem(s) and describe the symptoms.
X=sharp stabbing pain **///**=Throbbing
O=Dull achy pain **---** = Burning

History of Current Condition

Give a brief description of the problem(s) for which you are seeking therapy:_____

_____

When did this problem begin?_____

Treatment received so far for this problem (chiropractic, injections, etc.):_____

Have you ever had this problem before? Yes / No

If so, how was the problem treated?_____

How often do you wake at night due to your symptoms?_____

My symptoms are currently (circle one): Getting Better Getting Worse The Same

Aggravating Factors: Identify up to 2 important positions and activities that make your symptoms worse:

1._____

2._____

Easing Factors: Identify up to 2 important positions or activities that make your symptoms better:

1. _____

2. _____

What are your **goals** for therapy?_____

In the chart at the bottom please list three activities that you are having difficulty performing, or are unable to perform as a result of your problem. Please rate the difficulty level based on a 0 – 10 scale. (10 is the most difficult)

	Activity	Score 0-10
1.		
2.		
3.		

Allergies:_____

Are you **Latex**-Sensitive? Yes / No

Have you had any X-rays, CT scans, MRI, Bone Density scan, EMG, or Nerve Conduction study recently for this condition? Yes / No

If yes, when were the images taken and where?_____

Please list all current **Medications** (or provide list): _____

_____

_____

Past **Surgical History** and **Hospitalizations** (list all & dates): _____

_____

Currently I Am Experiencing (circle all that apply):

Fatigue	Fever/Chills/Sweats	Nausea/Vomiting/Indigestion
Weight Gain/Loss (Unintentional)	Difficulty Maintaining Balance with Walking	Dizziness
Numbness or Tingling	Muscle Weakness	Headaches
Bowel and Bladder Changes	Shortness of Breath	Memory Loss
Fainting	Difficulty Swallowing	Difficulty with Word Retrieval

Medical History: Please Circle Each Condition That You Have Been Told You Have (or Had).

Cancer	Heart Disease	High Blood Pressure	Chest Pain/Angina	Circulatory Problems
Kidney Disease	Liver Disease	Lung Disease	Asthma	Diabetes
Stroke	Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Thyroid dysfunction
Bone/Joint Infection	Depression	Anemia	Fibromyalgia	Chemical dependency

Other:_____

Do you have a pacemaker? Yes / No

Are you **currently** pregnant, or think you may be pregnant? Yes / No

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes / No

During the past month, have you often been bothered by having little interest or pleasure in doing things? Yes / No

Is this something with which you would like help (circle one)? Yes Yes, but not today No

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