Patient's Name: ______________________________ **DOB**: __________ **Phone Number**: ________________________

Referring Physician: __________________________ **Primary Care Physician**: ___________________________________

Complaint: ____________________________________ **Began**: _____________ **Avg Pain Score (0-10)**: ___________

Location: Upper Back Lower Back Head Neck Arms Hands Feet Other: _________________

Pain Travels To: Left Arm Right Arm Left Leg Right Leg Other: ____________________________________

Pain Quality: Constant Intermittent Sharp Dull Burning Throbbing Shooting Tingling Other: _________

What makes it worse: Walking Standing Sitting Bending Fwds Bending Bkwds Activity AM/PM Laying

What makes it better: Walking Standing Sitting Bending Fwds Bending Bkwds Ice Heat Massage Laying

Numbness: No Yes Where: ______________________ **Weakness**: No Yes Where: ______________________

Loss of control of your bowel or bladder: No Yes

What Imaging Studies have you had: MRI CT X-Ray EMG Bone Scan

Previous Treating Medications: ____

Previous Treatments/Injections: ____

Physical Therapy: No Yes **Completed**: No Yes **When**: ___________

Medical History: High Blood Pressure Heart Attack Heart Failure Murmur Recent Cold/Cough Asthma Bronchitis Liver Problems Kidney Problems Diabetes Thyroid Problems Seizure Stroke Fainting Cancer Prolonged Bleeding Other: ____

Surgical History - Dates needed: ____

____

Drug/Food Allergies: ____

Current Medications/Over-the-counter Medications/Vitamins: ____

____

Family History: Chronic Pain Depression Anxiety **Relationship to you:** ____________________________________

Currently Working: No Yes **Occupation:** __________________________________ **Last day of work**: ___________

Smoke History: No Yes **How many Packs/Day**: _______ **How many years**: ________ **When Quit**: ____________

Alcohol History: None Socially Excessive **Substance Abuse**: No Yes **Type**: ____________ **Date Quit**: _______

Patient Signature: ____ **Date**: ____________________