| 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 |

| **PROBLEMS** | |
|---|---|
| Please mark each condition that applies: | |
| Heart | ☐ |
| Stroke | ☐ |
| Diabetes | ☐ |
| COPD/ Asthma | ☐ |
| Blood Issues | ☐ |
| Hypertension/HBP | ☐ |
| Kidney Disease | ☐ |
| Cancer | ☐ |
| Other: | |

| **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:<br>☐ Yes ☐ No | Past Smoker:<br>☐ 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:<br>☐ Yes ☐ No | Past Use/Abuse:<br>☐ Yes ☐ No | When did you quit? |
| Duration of use/abuse of illicit drugs? | | Drug Involved:<br>☐ Cocaine ☐ Heroin ☐ Methamphetamine ☐ Alcohol<br>☐ 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:<br>_______ 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 |

Please mark the areas of your pain on the figures below.

| 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: