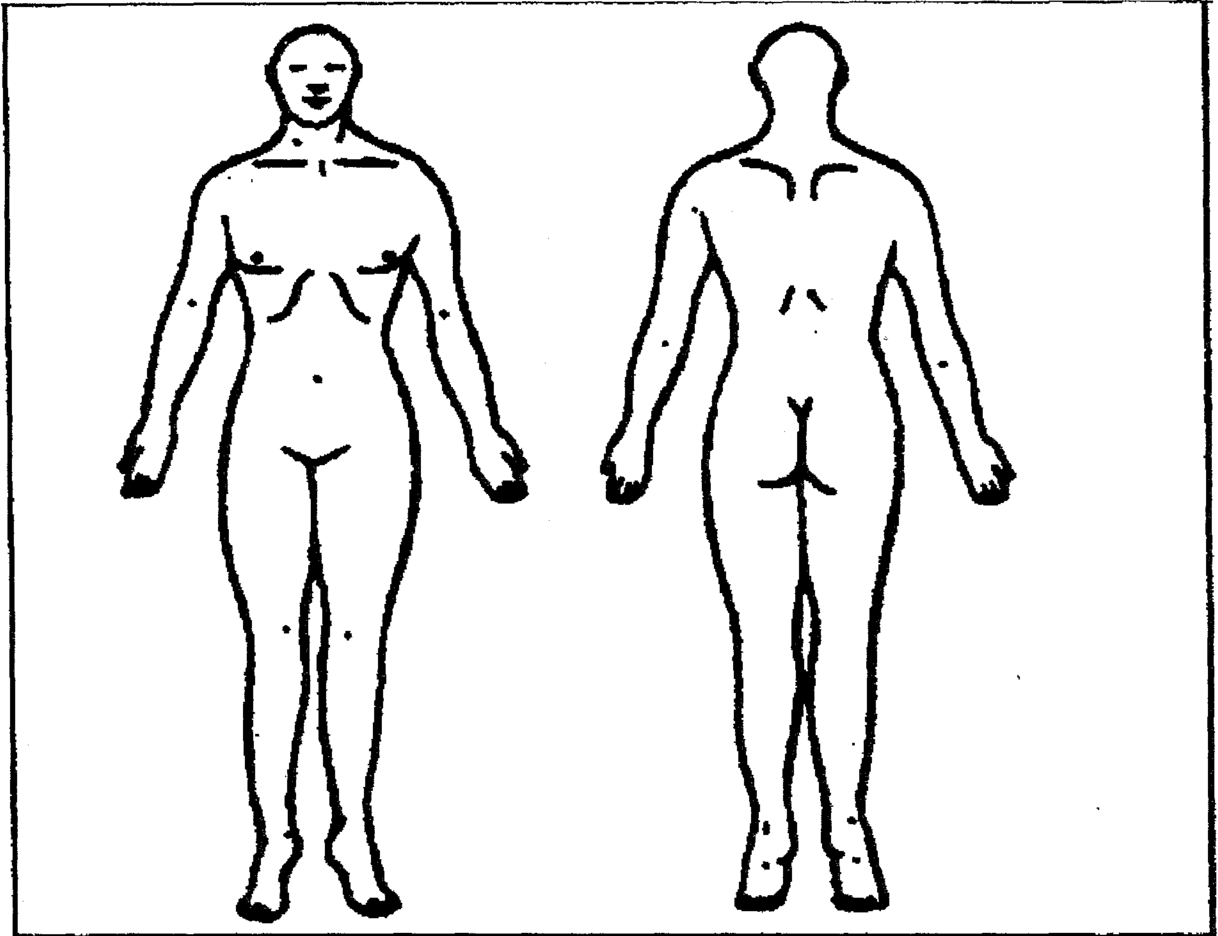
Patient Name: ______________________ Date: ____/____/____

Description of Symptoms

Mark Pain Area

Place an "X" at the location of pain and then describe your pain by placing the symbols below next to the "X"'s

Aching	A	Numbness	N	Shooting	H
Burning	B	Sharp	S	Stiffness	W
Constant	C	Tingling	T	Throbbing	R
Dull	D	Cramping	X	Other	O



Mark Pain Severity
(Where 0 is feeling no pain and 10 is feeling severe pain)

Neck
Right Now ____ 0 1 2 3 4 5 6 7 8 9 10
At Its Best ____ 0 1 2 3 4 5 6 7 8 9 10
At Its Worst ____ 0 1 2 3 4 5 6 7 8 9 10

Mid Back
Right Now ____ 0 1 2 3 4 5 6 7 8 9 10
At Its Best ____ 0 1 2 3 4 5 6 7 8 9 10
At Its Worst ____ 0 1 2 3 4 5 6 7 8 9 10

Low Back
Right Now ____ 0 1 2 3 4 5 6 7 8 9 10
At Its Best ____ 0 1 2 3 4 5 6 7 8 9 10
At Its Worst ____ 0 1 2 3 4 5 6 7 8 9 10

Hips
Right Now ____ 0 1 2 3 4 5 6 7 8 9 10
At Its Best ____ 0 1 2 3 4 5 6 7 8 9 10
At Its Worst ____ 0 1 2 3 4 5 6 7 8 9 10

Arms/Hands
Right Now ____ 0 1 2 3 4 5 6 7 8 9 10
At Its Best ____ 0 1 2 3 4 5 6 7 8 9 10
At Its Worst ____ 0 1 2 3 4 5 6 7 8 9 10

Legs/Feet
Right Now ____ 0 1 2 3 4 5 6 7 8 9 10
At Its Best ____ 0 1 2 3 4 5 6 7 8 9 10
At Its Worst ____ 0 1 2 3 4 5 6 7 8 9 10

Patient Basic Information

Date: ____/____/____

Last Name: ____________________ First Name: ____________________ Middle Initial: ____________

Address: ____________________ City, State, Zip: ____________________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________

Employer: ____________________ Status: ☐ M ☐S ☐ D ☐W ☐CHILD Spouse's Name: ____________

Social Security No.: ____________________ Date of Birth: ____________________ Date of Injury/Onset: ____________

Dominant Hand: ☐Right ☐Left ☐Both E-mail Address: ____________________

Who may we thank for referring you to our office: ____________________

Insurance Information:
Policy Holder (if different than patient): ____________________ Policy No.: ____________

1. Description of Accident/Injury/Onset *

Are your present problems due to an injury? ☐ Yes ☐ No ☐ On the Job ☐ Auto Collision ☐ Personal Injury
What was the date of your injury? ___/___/___ **Hour:**________ ☐ AM ☐ PM
Are you now or have you ever been disabled/impaired? (Service or Work?) ☐ Yes ☐ No When________________
Have you retained an attorney? ☐ Yes ☐ No Name & Address ____________________
Were there any witnesses? ☐ Yes ☐ No Name & Address ____________________
Did you have any physical complaints before the injury? ☐ Yes ☐ No Please Describe them in detail: ____________________

Are you off work? ☐ Yes ☐ No If yes, when was the last day you worked? ___/___/___
Type of work being done at the time of injury: ____________________

At this time, are you: ☐ **Improved** ☐ **Unchanged** ☐ **Getting Worse**
Have you ever been involved in an accident before? ☐ Yes ☐ No if yes, please describe, including dates and types of accidents as well as injuries received: ____________________

In your own words, please enter a full description of the accident, injury or onset in the space below.

2. During and after Injury details

Please describe how you felt:
During the accident: ____________________
Immediately after the accident: ____________________
Later that day: ____________________
The next day: ____________________

Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, please complete this question
Last day worked: ____________________
Type of employment: ____________________
Are you being compensated for time lost from work? ☐ Yes ☐ No If yes, please state the type of compensation you are receiving:

Enter the details of your condition during and after the accident/onset.

Patient Name: ______________________________ Date: ___/___/___

During the accident:
Did you lose consciousness during the injury? Yes❑❑No
If yes, for how long? ________________________

Emergency Room?
Where did you go after the accident?
❑Home ❑Work ❑Hospital ER ❑Private Doctor
How did you get there?
❑Self ❑Somebody else ❑Ambulance. ❑Police
X-rays done? Yes❑❑No Lab work? Yes❑❑No
Body parts X-rayed?____________________
What lab work?________________________
The X-rays revealed: ___________________
Treatments: ❑Cervical Collar❑Ice **Other:**____
Medications:___________________________
Follow-up instructions: _________________
____

After the accident:
Check off your symptoms following the accident:
❑Headache ❑Dizziness ❑Mid back pain ❑Cold hands
❑Neck pain ❑Nausea ❑Low back pain ❑Cold feet
❑Neck stiffness ❑Confusion ❑Nervousness ❑Diarrhea
❑Fainting ❑Fatigue ❑Loss of taste ❑Depression
❑Ringing in ears ❑Tension ❑Toe numbness ❑Anxious
❑Loss of smell ❑Irritability ❑Constipation ❑Chest Pain
❑Pain behind eyes ❑Shortness of breath ❑Sleeping problems
Others:___________________________________

Treatment History Relative To This Injury:
Fill in other doctor(s) seen prior to your first visit to this office.
1. Dr. ______________________ First visit date: ____/____/____
Specialty:______________________ X-rays done? **Yes❑❑No**
Types of treatments received:______________________________
How many treatments received? ____ Currently treating? **Yes❑❑No**
Did treatments benefit you? **Yes❑❑No** Last visit date: ____/____/____
2. Dr. ______________________ First visit date: ____/____/____
Types of treatments received:______________________________
How many treatments received? ____ Currently treating: **Yes❑❑No**
Did treatments benefit you? **Yes❑❑No** Last visit date: ____/____/____

Description of Symptoms
(Describe your symptoms in the sections below, in the order of severity, if possible.)

1. Major Complaint (Current Symptom I): (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.

1. Check only one body location below

Location	L	R	Both
❑Headaches	L❑	R❑	Both❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	L❑	R❑	Both❑
❑Eye	L❑	R❑	Both❑
❑Neck	L❑	R❑	Both❑
❑Upper Back	L❑	R❑	Both❑
❑Mid Back	L❑	R❑	Both❑
❑Low Back	L❑	R❑	Both❑
❑Chest	L❑	R❑	Both❑
❑Abdomen	L❑	R❑	Both❑
❑Ribs	L❑	R❑	Both❑
❑Buttocks	L❑	R❑	Both❑
❑Shoulder	L❑	R❑	Both❑
❑Upper Arm	L❑	R❑	Both❑
❑Forearm	L❑	R❑	Both❑
❑Hand	L❑	R❑	Both❑
❑Hip	L❑	R❑	Both❑
❑Leg	L❑	R❑	Both❑
❑Foot	L❑	R❑	Both❑

Other locations:______________

2. Types of pain
❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain:
____
____

3. Pain Frequency
❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activities)
❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:____________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forward	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
______________	❑	❑	❑
______________	❑	❑	❑

Additional Symptom Information

Please Rate Your Pain Severity For The Above Complaint
(Where 0 is feeling no pain and 10 is feeling severe pain)

Right Now 0 1 2 3 4 5 6 7 8 9 10 **At Its Best** 0 1 2 3 4 5 6 7 8 9 10 **At Its Worst** 0 1 2 3 4 5 6 7 8 9 10

Patient Name: ____________________________ Date: ____/____/____

2. Second Complaint (Current Symptom II): (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.

1. Check only one body location below

Location	L	R	Both
❑Headaches	L❑	R❑	Both❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	L❑	R❑	Both❑
❑Eye	L❑	R❑	Both❑
❑Neck	L❑	R❑	Both❑
❑Upper Back	L❑	R❑	Both❑
❑Mid Back	L❑	R❑	Both❑
❑Low Back	L❑	R❑	Both❑
❑Chest	L❑	R❑	Both❑
❑Abdomen	L❑	R❑	Both❑
❑Ribs	L❑	R❑	Both❑
❑Buttocks	L❑	R❑	Both❑
❑Shoulder	L❑	R❑	Both❑
❑Upper Arm	L❑	R❑	Both❑
❑Forearm	L❑	R❑	Both❑
❑Hand	L❑	R❑	Both❑
❑Hip	L❑	R❑	Both❑
❑Leg	L❑	R❑	Both❑
❑Foot	L❑	R❑	Both❑

Other locations:______________

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain:
____
____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activities)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:______________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forward	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
______________	❑	❑	❑
______________	❑	❑	❑

Additional Symptom Information

Please Rate Your Pain Severity For The Above Complaint
(Where 0 is feeling no pain and 10 is feeling severe pain)

Right Now 0 1 2 3 4 5 6 7 8 9 10 **At Its Best** 0 1 2 3 4 5 6 7 8 9 10 **At Its Worst** 0 1 2 3 4 5 6 7 8 9 10

3. Third Complaint (Current Symptom III): (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.

1. Check only one body location below

Location	L	R	Both
❑Headaches	L❑	R❑	Both❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	L❑	R❑	Both❑
❑Eye	L❑	R❑	Both❑
❑Neck	L❑	R❑	Both❑
❑Upper Back	L❑	R❑	Both❑
❑Mid Back	L❑	R❑	Both❑
❑Low Back	L❑	R❑	Both❑
❑Chest	L❑	R❑	Both❑
❑Abdomen	L❑	R❑	Both❑
❑Ribs	L❑	R❑	Both❑
❑Buttocks	L❑	R❑	Both❑
❑Shoulder	L❑	R❑	Both❑
❑Upper Arm	L❑	R❑	Both❑
❑Forearm	L❑	R❑	Both❑
❑Hand	L❑	R❑	Both❑
❑Hip	L❑	R❑	Both❑
❑Leg	L❑	R❑	Both❑
❑Foot	L❑	R❑	Both❑

Other locations:______________

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain:
____
____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activities)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:______________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forward	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
______________	❑	❑	❑
______________	❑	❑	❑

Additional Symptom Information

Please Rate Your Pain Severity For The Above Complaint
(Where 0 is feeling no pain and 10 is feeling severe pain)

Right Now 0 1 2 3 4 5 6 7 8 9 10 **At Its Best** 0 1 2 3 4 5 6 7 8 9 10 **At Its Worst** 0 1 2 3 4 5 6 7 8 9 10

Patient Name: ______________________________ Date: ___/___/___

4. Fourth Complaint (Current Symptom IV): (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.

1. Check only one body location below

❑Headaches L❑ R❑ Both❑
- ❑Front of Head
- ❑Top of Head
- ❑Back of Head

Location	L	R	Both
❑Jaw	L❑	R❑	Both❑
❑Eye	L❑	R❑	Both❑
❑Neck	L❑	R❑	Both❑
❑Upper Back	L❑	R❑	Both❑
❑Mid Back	L❑	R❑	Both❑
❑Low Back	L❑	R❑	Both❑
❑Chest	L❑	R❑	Both❑
❑Abdomen	L❑	R❑	Both❑
❑Ribs	L❑	R❑	Both❑
❑Buttocks	L❑	R❑	Both❑
❑Shoulder	L❑	R❑	Both❑
❑Upper Arm	L❑	R❑	Both❑
❑Forearm	L❑	R❑	Both❑
❑Hand	L❑	R❑	Both❑
❑Hip	L❑	R❑	Both❑
❑Leg	L❑	R❑	Both❑
❑Foot	L❑	R❑	Both❑

Other locations:______________

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain:
____
____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activities)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:____________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forward	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
____________	❑	❑	❑
____________	❑	❑	❑

Additional Symptom Information

Please Rate Your Pain Severity For The Above Complaint
(Where 0 is feeling no pain and 10 is feeling severe pain)

Right Now 0 1 2 3 4 5 6 7 8 9 10 **At Its Best** 0 1 2 3 4 5 6 7 8 9 10 **At Its Worst** 0 1 2 3 4 5 6 7 8 9 10

5. Fifth Complaint (Current Symptom V): (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.

1. Check only one body location below

❑Headaches L❑ R❑ Both❑
- ❑Front of Head
- ❑Top of Head
- ❑Back of Head

Location	L	R	Both
❑Jaw	L❑	R❑	Both❑
❑Eye	L❑	R❑	Both❑
❑Neck	L❑	R❑	Both❑
❑Upper Back	L❑	R❑	Both❑
❑Mid Back	L❑	R❑	Both❑
❑Low Back	L❑	R❑	Both❑
❑Chest	L❑	R❑	Both❑
❑Abdomen	L❑	R❑	Both❑
❑Ribs	L❑	R❑	Both❑
❑Buttocks	L❑	R❑	Both❑
❑Shoulder	L❑	R❑	Both❑
❑Upper Arm	L❑	R❑	Both❑
❑Forearm	L❑	R❑	Both❑
❑Hand	L❑	R❑	Both❑
❑Hip	L❑	R❑	Both❑
❑Leg	L❑	R❑	Both❑
❑Foot	L❑	R❑	Both❑

Other locations:______________

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain:
____
____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activities)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:____________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forward	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
____________	❑	❑	❑
____________	❑	❑	❑

Additional Symptom Information

Please Rate Your Pain Severity For The Above Complaint
(Where 0 is feeling no pain and 10 is feeling severe pain)

Right Now 0 1 2 3 4 5 6 7 8 9 10 **At Its Best** 0 1 2 3 4 5 6 7 8 9 10 **At Its Worst** 0 1 2 3 4 5 6 7 8 9 10

Patient Name: ______________________________ Date: ____/____/____

Activities of Daily Living Assessment (Only fill in areas affected.)

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty.

1 = "I can do it without any difficulty"
2 = "I can do it without much difficulty, despite some pain"
3 = "I manage to do it by myself, despite marked pain"
4 = "I manage to do it, despite the pain, but only if I have help"
5 = "I cannot do it at all, because of the pain"

Difficulties with Self Care and Personal Hygiene Activities

Bathing____ Drying hair____ Brushing teeth____ Putting on shoes____ Preparing meals____ Taking out trash____
Showering____ Combing hair____ Making bed____ Tying shoes____ Eating____ Doing laundry____
Washing hair____ Washing face____ Putting on shirt____ Putting on pants____ Cleaning dishes____ Going to toilet____

Difficulties with Physical Activities

Standing____ Walking____ Kneeling ____ Bending back ____ Twisting left____ Leaning back____
Sitting____ Stooping____ Reaching____ Bending left____ Twisting right____ Leaning left____
Reclining____ Squatting____ Bending forward____ Bending right____ Leaning forward____ Leaning right____
Standing for long periods____ Sitting for long periods____ Walking for long periods____ Kneeling for long periods____

Difficulties with Functional Activities

Carrying small objects____ Lifting weights off floor____ Pushing things while seated____ Exercising upper body____
Carrying large objects____ Lifting weights off table____ Pushing things while standing____ Exercising lower body____
Carrying brief case____ Climbing stairs____ Pulling things while seated____ Exercising arms____
Carrying large purse____ Climbing inclines____ Pulling things while standing____ Exercising legs____

Difficulties with Social and Recreational Activities

Bowling____ Jogging____ Swimming____ Ice Skating____ Competitive Sports____ Dating____
Golfing____ Dancing____ Skiing____ Roller Skating____ Hobbies____ Dining out____

Difficulties with Traveling

Driving a motor vehicle____ Riding as a passenger in a motor vehicle____ Riding as a passenger on a train____
Driving for long periods of time____ Riding as a passenger on an airplane____ Riding as a passenger for long periods____

Use the following **1 to 5** scale to describe the difficulties below:

1 = "This area is not affected by my condition"
2 = "This area is slightly affected by my condition"
3 = "My condition moderately restricts my ability in this area"
4 = " My condition seriously limits my ability in this area"
5 = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating____ Hearing____ Listening____ Speaking____ Reading____ Writing____ Using a keyboard____

Difficulties with the Senses

Seeing____ Hearing____ Sense of touch____ Sense of taste____ Sense of smell____

Difficulties with Hand Functions

Grasping____ Holding____ Pinching____ Percussive movements____ Sensory discrimination____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep____ Being able to participate in desired sexual activity____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

____
____
____
____
____

Patient Name: ______________________________ Date: ___/___/___

Prior Symptom History

Prior Similar Symptoms

- ❑ I have NOT had prior symptoms similar to my current complaints.
- ❑ My current complaints DID exist before, but had not been bothering me.
- ❑ My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- ❑ My history HAS contributed to my current symptoms.
- ❑ My history HAS NOT contributed to my current symptoms.
- ❑ I 'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms **(if applicable)** occurred____ ❑months ago / ❑years ago **OR on** Date:_____/_____/_____

Additional Historical Data

Write in below any other Prior Symptom History, not covered above:

____

____

____

____

____

Previous Illnesses (Have You Had Any Of The Following?)

Please enter: "2" (previously), or "3" (presently), in front of all of the following signs and symptoms. If not applicable put NA. A complete history and understanding of your health, will facilitate care. Behind the condition, put the number of times a month that the condition occurs.

General Symptoms

- ☐ 784.0 Headaches
- ☐ 780.6 Fever
- ☐ 780.99 Chills
- ☐ 780.8 Night Sweats
- ☐ 780.2 Fainting
- ☐ 780.4 Dizziness
- ☐ 780.3 Convulsions
- ☐ 780.52 Loss of Sleep
- ☐ 780.7 Fatigue
- ☐ 799.2 Nervousness
- ☐ 783. Loss of Weight
- ☐ 782. Numbness or pain in arms/legs/hands
- ☐ 995.3 Allergies
- ☐ 786.7 Wheezing
- ☐ 729.2 Neuralgia

Muscles and Joints

- ☐ 728.9 Weakness
- ☐ 781.0 Twitching
- ☐ 723.5 Stiff Neck
- ☐ 724.5 Backache
- ☐ 719.0 Swollen Joints
- ☐ 781. Tremors
- ☐ 729.5 Foot Trouble
- ☐ 724.79 Painful Tailbone
- ☐ 724.5 Pain between Shoulders
- ☐ 737.3 Spinal Curvature

Gastro-Intestinal

- ☐ 783. Poor Appetite
- ☐ 536.8 Poor Digestion
- ☐ 994.2 Starvation
- ☐ 787.3 Belching or Gas
- ☐ 787.0 Nausea
- ☐ 787.0 Vomiting
- ☐ 578.0 Vomiting Blood
- ☐ 536.8 Pain over Stomach
- ☐ 564.0 Constipation
- ☐ 787.91 Diarrhea
- ☐ 562.1 Colon Trouble
- ☐ 455.6 Hemorrhoids (Piles)
- ☐ 776.7 Fluid Retention
- ☐ 873.9 Liver Trouble
- ☐ 274. Gout
- ☐ 782.4 Jaundice
- ☐ 575.9 Gall Bladder Trouble

Cardio-Vascular

- ☐ 785.0 Rapid Heart Beat
- ☐ 427.89 Slow Heart Beat
- ☐ 401.9 High Blood Pressure
- ☐ 458.9 Low Blood Pressure
- ☐ 786.51 Pain over Heart
- ☐ 429.9 Heart Trouble
- ☐ 719.07 Swelling Ankles
- ☐ 459.9 Poor Circulation
- ☐ 454.9 Varicose Veins
- ☐ 436. Strokes
- ☐ 785.1 Palpitations

Eye/Ear/Nose/Throat

- ☐ 368.9 Poor Vision
- ☐ 378.0 Crossed Eyes
- ☐ 379.91 Pain in Eyes
- ☐ 389.9 Deafness
- ☐ 388.70 Earache
- ☐ 388.30 Ear Noises
- ☐ 388.60 Ear Discharges
- ☐ 478.1 Nasal Obstruction
- ☐ 784.4 Nose Bleeds
- ☐ 462. Sore Throats
- ☐ 784.49 Hoarseness
- ☐ 477.9 Hay Fever
- ☐ 493.9 Asthma
- ☐ 460. Frequent Colds
- ☐ 240.9 Enlarged Thyroid
- ☐ 463. Tonsillitis
- ☐ 473. Sinus Trouble

Skin or Allergies

- ☐ 680. Skin Eruptions
- ☐ 698.9 Itching
- ☐ 924.9 Bruising Easily
- ☐ 701.1 Dryness
- ☐ 680.9 Boils
- ☐ 782. Sensitive Skin
- ☐ 708.9 Hives or Allergy
- ☐ 692.9 Eczema
- ☐ Medicines: ________________ ________________

Respiratory

- ☐ 786.2 Chronic Cough
- ☐ 786.3 Spitting Blood
- ☐ 786.4 Spitting Phlegm
- ☐ 786.50 Chest Pain
- ☐ 786.09 Difficulty Breathing

Genito-Urinary

- ☐ 788.4 Frequent Urination
- ☐ 788.1 Painful Urination
- ☐ 599.7 Blood in Urine
- ☐ 590. Kidney Infection
- ☐ 788.3 Bed Wetting
- ☐ 788.3 Inability to control Urine
- ☐ 601.9 Prostate Trouble

For Women Only

- ☐ 625.3 Painful Periods
- ☐ 626.2 Excessive Flow
- ☐ 626.4 Irregular Cycle
- ☐ 627.2 Hot Flashes
- ☐ 625.3 Cramps or Backaches
- ☐ 623.5 Vaginal Discharge
- ☐ Pregnant at this Time
- ☐ Last Pap

By Whom ___________________

Other______________________

Other Health Conditions

- ☐ 303.9 Alcoholism
- ☐ 280. Anemia
- ☐ 541. Appendicitis
- ☐ 716. Arthritis
- ☐ 239. Cancer
- ☐ 052. Chicken Pox
- ☐ 250. Diabetes
- ☐ 345. Epilepsy
- ☐ 240. Goiter
- ☐ 429.9 Heart Disease
- ☐ 042. HIV Positive
- ☐ 487. Influenza
- ☐ 055. Measles
- ☐ 319. Mental Disorder
- ☐ 072. Mumps
- ☐ 511. Pleurisy
- ☐ 480. Pneumonia
- ☐ 045. Polio
- ☐ 390. Rheumatic Fever
- ☐ 737.30 Scoliosis
- ☐ 846. Sprain/Strain Sacroiliac
- ☐ 847.0 Whiplash

Patient Name: ______________________________ Date: ___/___/___

Additional Historical Data (continued)

Have you ever had any accidents or falls of any kind? List dates:
☐ Car ________________ ☐ Recreational Vehicle ________________ ☐ Sports ________________
☐ School ________________ ☐ Other ________________

List any broken bones (fractures) or dislocations: ________________
Have you ever been on crutches? ☐ Yes ☐ No Why? ________________
Have you ever had a lapse of memory? ☐ Yes ☐ No **Have you ever been unconscious?** ☐ Yes ☐ No
Have you ever had X-rays taken? ☐ Yes ☐ No When? ________________ By Whom? ________________
For what ailments were these x-rays taken? ________________
Do you suffer from any condition other than that for which you are now consulting us? ________________
Have you had any nervous or mental illnesses? ☐ Yes ☐ No
Have you ever had psychiatric care? ☐ Yes ☐ No
If yes, please list the type of care and dates: ________________
Are you presently taking any medication – prescription or over-the-counter? ☐ Yes ☐ No If yes, please list:

Medication	Reason for taking

Social & Occupational History Section

Occupation ________________ Employer ________________
Shift 1 2 3 Description ________________ Years Worked ________________

Work Activity	Exercise	Habits	
☐ Sitting ____%	☐ None	☐ Smoking	Packs/Day ________
☐ Standing ____%	☐ Moderate	☐ Alcohol	Drinks/Week ________
☐ Light Labor ____%	☐ Daily	☐ Coffee/Caffeine Drinks	Cups/Day ________
☐ Heavy Labor ____%	☐ Heavy	☐ High Stress Level	Reason ________

Please circle the corresponding time for each activity in a typical 8 hour workday

Sit	1	2	3	4	5	6	7	8	Hours
Stand	1	2	3	4	5	6	7	8	Hours
Walk	1	2	3	4	5	6	7	8	Hours

On the job I perform the following activities: (in terms of an 8 hour workday, "Occasionally" means 33% of the time, "Frequently" means 34% to 66%, and "Continuously" means 67% to 100% of the day)

Bend/Stoop	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Squat	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Crawl	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Climb	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Reach above shoulder level	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Crouch	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Kneel	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Balancing	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Pushing/Pulling	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously

On the job, I lift: (in terms of an 8 hour workday, "Occasionally" means 33% of the time, "Frequently" means 34% to 66%, and "Continuously" means 67% to 100% of the day)

Up to 10 pounds	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
11 to 24 pounds	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
25 to 34 pounds	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
35 to 50 pounds	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
51 to 74 pounds	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
75 to 100 pounds	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously

Do you have to bend over while doing any lifting? Y ☐ N ☐
Are your feet used for repetitive movements, such as operating foot controls? Y ☐ N ☐
Do you use your hands for repetitive movements, such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
Right Hand	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Left Hand	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

Patient Name: ______________________________ Date: ___/___/___

Social & Occupational History Section (continued)

Are you required to work on unprotected heights? Y ☐ N ☐ If yes, please describe:______________________

____

Are you required to be around moving machinery? Y ☐ N ☐ If yes, please describe:______________________

____

Are you exposed to marked changes in temperature and humidity? Y ☐ N ☐ If yes, please describe:______________

____

Are you required to drive automotive equipment? Y ☐ N ☐ If yes, please describe:______________________

____

Are you exposed to dust, fumes, and/or gases? Y ☐ N ☐ If yes, please describe:______________________

____

Family History

	Diabetes	Heart	Kidney	Cancer	Back
Mother – Living Y ☐ **N** ☐	☐	☐	☐	☐	☐
Father – Living Y ☐ **N** ☐	☐	☐	☐	☐	☐
Brother(s), # of __	☐	☐	☐	☐	☐
Sister(s), # of __	☐	☐	☐	☐	☐

Status ☐ Single ☐ Married ☐ Separated ☐ Widowed

Spouse ______________________

Spouse's Occupation ______________________

Spouse's Employer ______________________

List Children (Names and Ages)

____

____

____

Patient Signature______________________________________ Date ___/___/___

The BACK Bournemouth Questionnaire

The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have your been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Patient name ______________________ **Patient signature** ______________________ **Date** ______

Bolton JE, Breen AC. The Bournemouth Questionnaire: a short-form comprehensive outcome measure. I. Psychometric properties in back pain patients. J Manipulative Physiol Ther 1999;22:503-10

The NECK Bournemouth Questionnaire

The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have your been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Patient name ______________________ **Patient signature** ______________________ **Date** ______

Bolton J, Humphreys BK. The Bournemouth Questionnaire: A short-form comprehensive outcome measure. II. Psychometric properties in neck pain patients. J Manipulative Physiol Ther 2002;25:141-148.