Name: _____ Date: _____

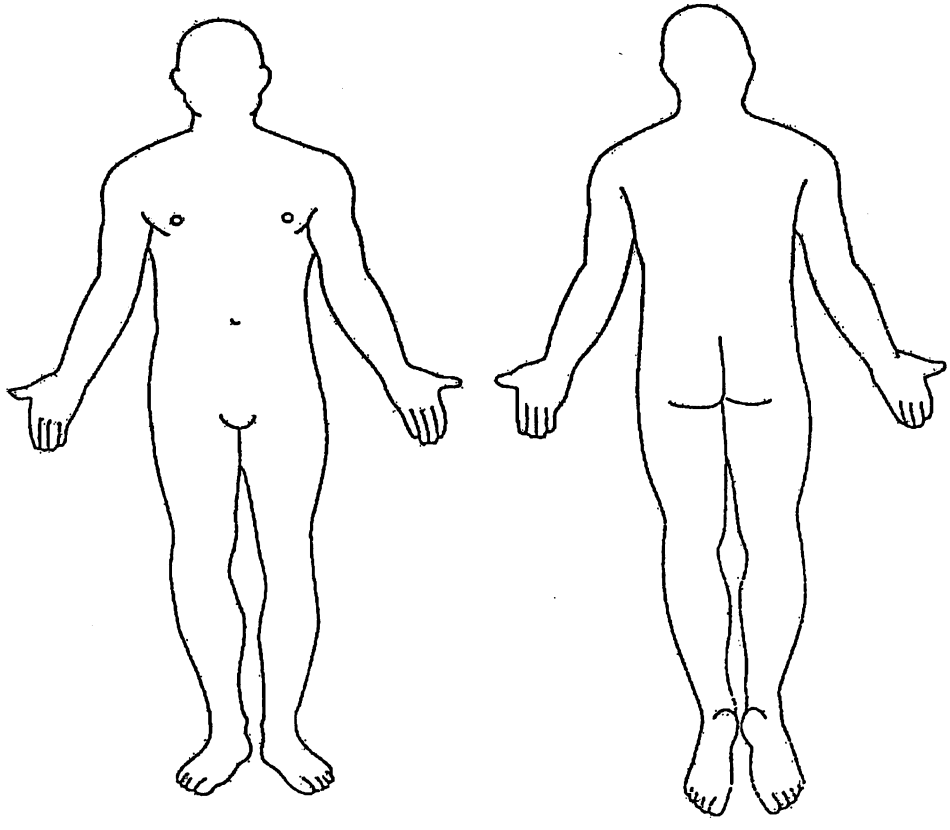
WHERE IS YOUR PAIN?

1. Please mark, on the drawings below, the areas where you feel pain. Put "E" if external, "I" if internal, "EI" if both external and internal, near the areas which you mark. Also, if you have one or more areas which can trigger your pain when pressure is applied to them, mark each with an "X".

2. Mark the areas on you body where you feel the described sensations. Include all affected areas. Use the appropriate symbol.

Numbness ====== Pins & Needles oooooo Ache ^^^^^^

Burning xxxxxx Stabbing //////



Comments: _____

_____

_____

_____

_____

Date: _____ Chart # _____ Doctor: _____

Patient Name (Please Print) _____ Patient Signature _____

Age _____ ☐F ☐M Height _____/_____ Weight _____ Did you bring x-rays? ☐Y ☐N

Who requested that you visit this office? ☐Doctor (Name) _____ ☐Self-Referral ☐Attorney _____

What is the main reason for this visit? ☐Pain ☐Numbness ☐Weakness ☐Other _____(Chief Complaint)

What body part is involved?												**(Location)**
Neck ☐		Shoulder	☐R ☐L	Elbow	☐R ☐L	Hand	☐R ☐L	Pelvis	☐R ☐L	Knee	☐R ☐L	Foot	☐R ☐L
Back ☐Mid ☐Lower		Arm	☐R ☐L	Wrist	☐R ☐L	Finger	☐R ☐L	Hip &/or Thigh	☐R ☐L	Ankle	☐R ☐L	Toe	☐R ☐L

How long has this problem been present? _____ ☐Days ☐Weeks ☐Months

Check the box which best fits <u>how your problem started</u>. Then answer the <u>one</u> question below the box you checked. Use as much space to the right as needed.

ANSWER:

☐**NO INJURY (Onset was:** ☐Gradual or ☐Sudden)

?Why do you think it started?

☐**INJURY** - (<u>NOT</u> AUTO OR WORK)

Date_____, Where and How did it Happen?

☐**INJURY AT WORK**

Date_____, Where and How did it Happen?

☐**WORK RELATED - (BUT <u>NO</u> INJURY)**

Date_____, How did you job cause this problem?

☐**AUTO ACCIDENT**

Date_____, Where and How was your car hit?

Please check the box below which best describes your problem:

The pain is ☐Constant ☐Comes and goes (Intermittent) in duration **(Duration)**

<u>Severity</u> of pain ☐Mild ☐Moderate ☐Severe ☐Extremely severe **(Severity)**

What is the **<u>quality</u>** of the pain? ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning ☐Other_____**(Quality)**

Are there **<u>associated symptoms</u>**? ☐Swelling ☐Numbness ☐Weakness ☐Fever ☐Weight Loss **(Assoc Symp)**

Since my problem started, it is: ☐Getting better ☐Getting worse ☐Unchanged **(Context)**

Does your pain wake you up from sleep? ☐Yes ☐No **(Timing)**

What makes your symptoms **<u>worse</u>**? ☐Activity ☐Exercise ☐Work ☐Other_____ **(Modify)**

Which make you feel **<u>better</u>**? ☐Rest ☐Heat ☐Ice ☐Elevation ☐Other_____ **(Modify)**

What medications have you taken or been prescribed for this problem? _____ **(Modify)**

Check which treatments you have tried: Injection☐Y ☐N Brace☐Y ☐N Therapy☐Y ☐N Cane/Crutch☐Y ☐N **(Modify)**

Name: _____ _____ Date: _____

REVIEW OF SYSTEMS: Do you have now, or have you ever had, any of the following problems?
(Please check any that apply, or mark None)

		None	Year	Explain Details/Comments
1)**MS**	☐Numbness☐Weakness ☐Prior Fracture ☐Arthritis	☐	_____	_____
	☐Back Pain ☐Joint Swelling ☐Cramps ☐Osteoporosis	☐	_____	_____
2)**CON**	☐Unexpected weight loss ☐Loss of appetite ☐Fever	☐	_____	_____
3)**EYE**	☐Glasses ☐Contacts ☐Double vision ☐Cataract	☐	_____	_____
4)**ENT**	☐Hearing Loss ☐Hoarseness ☐Ringing in Ears	☐	_____	_____
5)**CV**	☐High blood pressure ☐Heart Attack ☐Blood clots	☐	_____	_____
6)**RS**	☐Asthma ☐Cough ☐Pneumonia ☐Short of Breath ☐TB	☐	_____	_____
7)**GI**	☐Stomach ulcer ☐Hepatitis ☐Blood in Stool	☐	_____	_____
8)**GU**	☐Pain with Urination ☐Blood in Urine ☐Kidney disease	☐	_____	_____
9)**SK**	☐Skin Ulcers ☐Rash ☐Lumps	☐	_____	_____
10)**NEU**	☐Seizures ☐Stroke ☐Balance Problem ☐Headaches	☐	_____	_____
11)**PSY**	☐Depression ☐Nervousness ☐Sleep disorder	☐	_____	_____
12)**END**	☐Thyroid disorder ☐Hypoglycemia ☐Excessive Thirst	☐	_____	_____
13)**HEM**	☐Easy bleeding ☐Easy bruising ☐Anemia	☐	_____	_____

Have you ever had cancer? ☐Y ☐N (Indicate Location) _____

ARE YOU A DIABETIC? ☐Y ☐N TREATMENT: ☐Insulin ☐Oral Meds ☐Diet ☐None

PAST MEDICAL HISTORY

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐Y ☐N If yes, please list _____

_____

ARE YOU TAKING, OR HAVE YOU EVER TAKEN, BLOOD THINNERS? (Aspirin and Ibuprofen are blood thinners)
☐Y ☐N If yes, (type) _____

☛ **WHAT MEDICATIONS DO YOU TAKE?** Please list with dosage: _____

_____

PAST HOSPITALIZATIONS (Not for surgery) _____

PAST SURGICAL HISTORY: What operations have you had? When? _____

_____

Have you ever had a reaction to anesthesia? ☐Y ☐N

FAMILY HISTORY: Have any family members had any of the following disorders? If so, which relative?

Arthritis ☐Y ☐N _____ Heart disease ☐Y ☐N _____ High Blood Pressure ☐Y ☐N _____
Cancer ☐Y ☐N _____ Diabetes ☐Y ☐N _____ Back Pain ☐Y ☐N _____

SOCIAL HISTORY:

Do you use tobacco? ☐Y ☐N Packs per day ___ Do you use alcohol? ☐Y ☐N How often? ☐Daily ☐Other_____
Marital History: M S D W How many people live with you: _____
Occupation: _____ ☐Student Employer: _____
Are you currently working? ☐Y ☐N If no, how long have you been off work? _____