Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question

STAFF: Handwritten responses must be entered **MANUALLY**.

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

FACTORS OF COMPLAINT

What do you want to happen as a result of this visit? _____

_____

_____

How and when did your problem begin? (Please mark each answer that applies to your neck / back pain.)

I don't know how it began ○ It comes and goes ○ I've had it a long time (_____years) ○

Injury (date of injury_____) ○ **Was your injury on the job?** yes ○ no ○

Please explain how the injury happened: _____

_____

Are you currently in litigation with regard to your back pain? yes ○ no ○

Have you been laid off from your job? yes ○ no ○ n/a ○

How bad is your pain? Mark the scales below to indicate your pain for each area.

How bad is your **low back** pain?

☺ No Pain ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ☹ Worst Possible Pain

How bad is your **leg** pain?

☺ No Pain ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ☹ Worst Possible Pain

How bad is your **middle back** pain?

☺ No Pain ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ☹ Worst Possible Pain

How bad is your **neck** pain?

☺ No Pain ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ☹ Worst Possible Pain

How bad is your **arm** pain?

☺ No Pain ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ☹ Worst Possible Pain

Is your pain worse at night? yes ○ no ○

Does your pain awaken you from sleep ? yes ○ no ○

Does coughing affect your pain? yes ○ no ○

Do your legs tire / hurt if you walk too far? yes ○ no ○

If yes, how far can you walk? 1 block ○ 1-3 blocks ○ more than 3 blocks ○

Is this relieved by resting your legs? yes ○ no ○

Is this relieved by bending forward? yes ○ no ○

Bladder control (urine): no problem ○ can't empty bladder ○ loss of urine (accidents) ○

Bowel control: no problem ○ constipation ○ loss of control (accidents) ○

How does each of the following affect your pain?

Sitting	better ○	worse ○	no change ○	
Standing	better ○	worse ○	no change ○	
Walking	better ○	worse ○	no change ○	
Lying down	better ○	worse ○	no change ○	
Rising from chair	better ○	worse ○	no change ○	
Physical activity	better ○	worse ○	no change ○	
Heat	better ○	worse ○	no change ○	don't know ○
Cold	better ○	worse ○	no change ○	don't know ○
Massage	better ○	worse ○	no change ○	don't know ○

Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question

STAFF: Handwritten responses must be entered **MANUALLY**.

PREVIOUS TREATMENT

We need to know about the treatments you have already received for your current back / neck pain.
If YES to any of the following, did it make your condition better, worse, or no change?

◯ I have had no previous treatment for my current back / neck pain.			
◯ Chiropractic care	◯ better	◯ worse	◯ no change
◯ Physical therapy	◯ better	◯ worse	◯ no change
◯ Injections	◯ better	◯ worse	◯ no change
◯ Psychological consultations	◯ better	◯ worse	◯ no change
◯ Other: _____	◯ better	◯ worse	◯ no change

For your current back / neck pain, please mark the ovals for the time frame that any tests were done.

◯ I have had no previous tests for my current back / neck pain.		
◯ X-rays	◯ <6 months	◯ <12 months
◯ MRI scan	◯ <6 months	◯ <12 months
◯ CT scan	◯ <6 months	◯ <12 months
◯ Myelogram	◯ <6 months	◯ <12 months
◯ Discogram	◯ <6 months	◯ <12 months
◯ EMG / NCV (nerve test)	◯ <6 months	◯ <12 months

Have you ever had surgery on your back or neck? ◯ yes ◯ no

If YES, please complete the following:

Surgery #1
Type of surgery: _____

Date: _____ **Surgeon:** _____

Did it make your pain: ◯ better ◯ worse ◯ no change

Surgery #2
Type of surgery: _____

Date: _____ **Surgeon:** _____

Did it make your pain: ◯ better ◯ worse ◯ no change

Surgery #3
Type of surgery: _____

Date: _____ **Surgeon:** _____

Did it make your pain: ◯ better ◯ worse ◯ no change