| Reason for visit | ❑ Neck pain ❑ Back pain ❑ Surgical consult ❑ Other: |
|---|---|

| PLEASE LIST ALL KNOWN ALLERGIES AND YOUR REACTION | |
|---|---|
| | Reaction type: |
| | Reaction type: |
| | Reaction type: |
| PLEASE INDICATE IF YOU ARE ALLERGIC TO THE FOLLOWING:<br>❑ IODINE ❑ SHELLFISH ❑ LATEX | |
| ❑ NO KNOWN MEDICATION ALLERGIES | |

| CURRENT MEDICATIONS Please list all medications with dosage and the frequency that you take them. Please include herbal and over-the-counter drugs. Use an additional sheet if necessary | |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

| PAST FAMILY HISTORY PLEASE INDICATE YOUR RELATION | | |
|---|---|---|
| ❑ HIGH BLOOD PRESSURE | ❑ HEART DISEASE | ❑ DIABETES |
| ❑ NEUROLOGICAL DISEASE | ❑ DEPRESSION/ANXIETY | ❑ SLEEP APNEA/COPD |
| ❑ CANCER(TYPE): | ❑ BIPOLAR DISORDER | ❑ OTHER: |

| SOCIAL HISTORY | | | |
|---|---|---|---|
| WHAT ARE YOUR HOBBIES? | | | |
| DO YOU SMOKE? | ❑ YES ❑ NO | PACKS/DAY | YEARS |
| ALCOHOL USE? | ❑ YES ❑ NO | DRINKS/DAY | |
| OTHER SUBSTANCES? | ❑ YES ❑ NO | LIST: | LAST USED: |

| SURGICAL HISTORY: PLEASE LIST | | | |
|---|---|---|---|
| SURGERY | | DATE: | |
| SURGERY | | DATE: | |
| SURGERY | | DATE: | |
| DO YOU HAVE ANY IMPLANTED DEVICES? | | | |
| ❑ SCREWS, PINS, PLATES | ❑ PACEMAKER | ❑ IUD | ❑ VENOUS ACCESS |
| ❑ ANEURYSM CLIP(S) | ❑ AICD | ❑ BREAST IMPLANT | ❑ SPINAL CORD STIMULATOR |
| ❑ INTRATHECAL PUMP | | | |

| PAST MEDICAL HISTORY | | |
|---|---|---|
| ❑ GASTRIC REFLUX | ❑ COPD/SLEEP APNEA | ❑ HYPERTENSION |
| ❑ ANXIETY/DEPRESSION: | ❑ DIABETES | ❑ NEUROLOGICAL DISEASE |
| ❑ CANCER (TYPE): | ❑ HEART DISEASE | ❑ OTHER: |
| *HAVE YOU EVER HAD OR BEEN TOLD YOU HAVE MRSA?* ❑ YES ❑ NO | | |

## REVIEW OF SYSTEMS

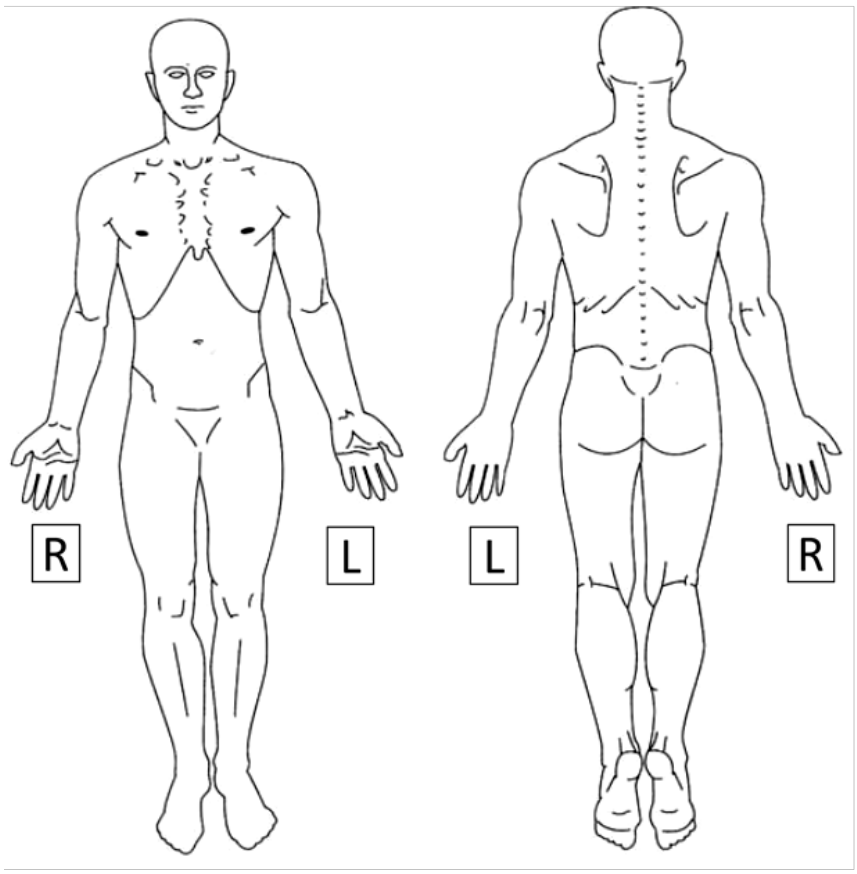
***Please check below if you have, or recently experienced, any of these medical conditions:***

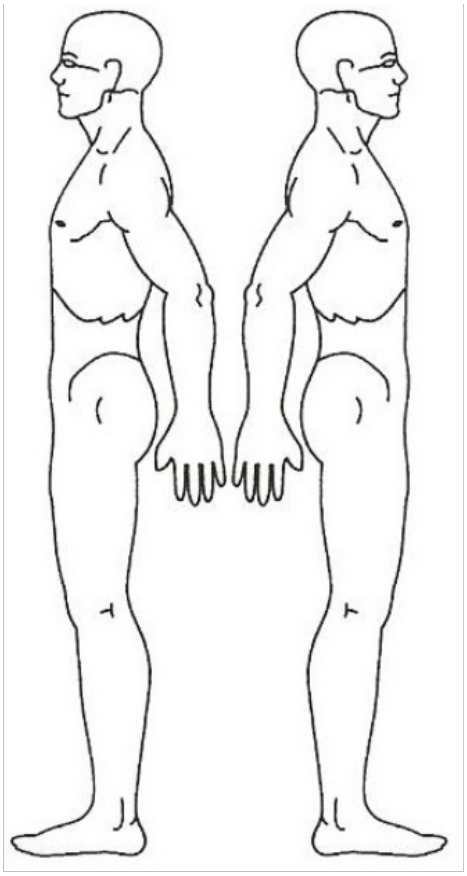
| | | | | | |
|---|---|---|---|---|---|
| Fever | Y□ N □ | Palpitations | Y□ N □ | Seizures | Y□ N □ |
| Weight gain | Y□ N □ | Shortness of breath | Y□ N □ | Psychological problems | Y□ N □ |
| Weight loss | Y□ N □ | Abdominal pain | Y□ N □ | Depression | Y□ N □ |
| Chills/Night sweats | Y□ N □ | Black/tarry stools | Y□ N □ | Anxiety | Y□ N □ |
| Changes to vision | Y□ N □ | Urinary Incontinence | Y□ N □ | Fatigue | Y□ N □ |
| Dental problems | Y□ N □ | Leg or arm swelling | Y□ N □ | Swollen glands | Y□ N □ |
| Chest pain | Y□ N □ | Skin wounds | Y□ N □ | Easy bruising | Y□ N □ |
| Irregular heart beat | Y□ N □ | Rash | Y□ N □ | Easy bleeding | Y□ N □ |

| HOW DID THIS PAIN BEGIN? | | | |
|---|---|---|---|
| ❑ AUTOACCIDENT | ❑ AT WORK | ❑ AT HOME | ❑ FOLLOWING SURGERY |
| ❑ AFTER AN ILLNESS - TYPE? | ❑ GRADUALLY | | |
| ❑ OTHER /UNKOWN: | | | |
| IF AN ACCIDENT OR INJURY CAUSED YOUR PAIN, PLEASE BRIEFLY DESCRIBE | | | |
| | | | |

| WHEN DID THE PAIN BEGIN OR WHAT WAS THE DATE OF YOUR INJURY? |
|---|
| |

| PLEASE MARK WHERE YOUR PAIN IS. PLEASE USE THE SYMBOLS TO INDICATE WHAT TYPE OF PAIN YOU EXPERIENCE IN EACH AREA. | | | | |
|---|---|---|---|---|
| ACHING | BURNING | NUMBNESS | PINS AND NEEDLES | STABBING |
| ΔΔΔΔΔΔΔ | XXXXXXXX | ========== | oooooo | ///////// |



LEFT SIDE RIGHT SIDE

PLEASE RATE THE SEVERITY OF YOUR PAIN ON A SCALE OF 1 TO 10

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| TODAY | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| BEST DAY | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| WORST DAY | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**SCALE**

0 = NO PAIN
1 = VERY MILD PAIN: YOU ARE AWARE OF THE PAIN BUT IT DOESN'T BOTHER YOU
2 = MILD PAIN THAT YOU CAN TOLERATE WITHOUT TAKING MEDICATION
3 = MILD TO MODERATE PAIN THAT REQUIRES MEDICATION TO TOLERATE
4-5 = MODERATE PAIN THAT SOMETIMES IS NOT CONTROLLED AND CAUSES YOU TO FEEL ANTISOCIAL
6 = FAIRLY SEVERE PAIN THAT INTERFERES WITH DAILY LIFE.
7-9 = INTENSELY SEVERE PAIN
10 = WORST PAIN IMAGINABLE

| HOW OFTEN DO YOU HAVE PAIN? | |
|---|---|
| ❑ CONSTANTLY (100% OF THE TIME) | ❑ INTERMITTENTLY (50% OF THE TIME) |
| ❑ FREQUENTLY (75% OF THE TIME) | ❑ OCCASIONALLY (25% OF THE TIME) |

| WHAT MAKES THE PAIN FEEL BETTER? | | | |
|---|---|---|---|
| ❑ WALKING | ❑ LEANING FORWARD | ❑ RELAXATION | ❑ HEAT |
| ❑ LYING FLAT | ❑ LYING WITH HIPS / KNEES BENT | ❑ REST | ❑ ICE |
| ❑ INTRATHECAL PUMP | ❑ OTHER: | | |

| WHAT MAKES THE PAIN WORSE? | | |
|---|---|---|
| ❑ STANDING | ❑ LAYING DOWN | ❑ BOWEL MOVEMENTS |
| ❑ SITTING | ❑ LIFTING | ❑ COUGHING / SNEEZING |
| ❑ GETTING UP OUT OF BED | ❑ BENDING FORWARD | ❑ DAMP WEATHER |
| ❑ WALKING | ❑ BENDING BACKWARD | ❑ RAISING OUT OF A CHAIR |
| ❑ COLD | ❑ URINATION | ❑ EXERCISE |
| ❑ OTHER: | | |

| DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? | | |
|---|---|---|
| ❑ NUMBNESS | ❑ BLADDER INCONTINENCE | ❑ WEAKNESS IN ARM OR LEG |
| ❑ TINGLING | ❑ BOWEL INCONTINENCE | ❑ JOINT SWELLING |

| HAVE YOU EVER HAD SURGERY ON YOUR BACK OR NECK? |
|---|
| ❑ YES ❑ NO |
| AT WHAT LEVEL? WHEN? Who performed the surgery? |
| |

| WHAT TREATMENTS HAVE YOU TRIED BEFORE? | | |
|---|---|---|
| ❑ REST/ACTIVITY MODIFICATION | ❑ ACUPUNCTURE | ❑ CHIROPRACTOR VISITS |
| ❑ STEROID / CORTISONE INJECTIONS | ❑ HEAT THERAPY | ❑ PHYSICAL THERAPY |
| ❑ ELECTRICAL STIMULATION (TENS) | ❑ NERVE BLOCK | ❑ MASSSAGE THERAPY |
| ❑ BIOFEEDBACK | ❑ PSYCHOTHERAPY | ❑ OTHER: |

| HAVE YOU TRIED ANY OF THESE MEDICATIONS FOR YOUR PAIN? | |
|---|---|
| ❑ ACETAMINOPHEN (TYLENOL) | ❑ ANTIDEPRESSANT |
| ❑ GABAPENTIN (NEURONTIN) | ❑ ORAL STEROID (MEDROL DOSE PAK) |
| ❑ IBUPROFEN (ADVIL) | ❑ PREGABALIN (Lyrica) |
| ❑ NAPROXEN (ALEVE) | ❑ OPIOID (NARCOTIC) |
| ❑ OTHER | |

| DO YOU HAVE A PERSONAL HISTORY OF? | | |
|---|---|---|
| ❑ ALCOHOL ABUSE | ❑ ILLEGAL DRUG USE | ❑ PRESCRIPTION DRUG ABUSE |
| DID YOU SEEK PROFESSIONAL TREATMENT OR DETOXIFICATION | | |
| ❑ YES ❑ NO | | |

| DO YOU HAVE A FAMILY HISTORY OF? | | | |
|---|---|---|---|
| ❑ ALCOHOL ABUSE | | ❑ ILLEGAL DRUG USE | ❑ PRESCRIPTION DRUG ABUSE |
| WHO: | ❑ FATHER ❑ MOTHER ❑ CHILD ❑ SIBLING | | |

| DO YOU HAVE A DIAGNOSIS OF? | | |
|---|---|---|
| ❑ ADD/ADHD | ❑ OCD | ❑ BI-POLAR |
| ❑ SCHIZOPHRENIA | ❑ DEPRESSION | ❑ OTHER |
| ARE YOU ON A MEDICATION FOR ANY OF THE ABOVE? | | |
| NAME: | | |

| DO YOU HAVE A HISTORY OF PRE-ADOLESCENT SEXUAL ABUSE? |
|---|
| ❑ YES ❑ NO |

| HAVE YOU HAD ANY OF THE FOLLOWING STUDIES? | | |
|---|---|---|
| ❑ MRI | ❑ X-RAY | ❑ CT SCAN |
| ❑ MYELOGRAM | ❑ DISCOGRAM | ❑ EMG/NCV |
| ❑ BONE SCAN | ❑ OTHER: | |

| HAVE YOU SEEN ANY OTHER PHYSICIAN FOR THIS PAIN? | |
|---|---|
| ❑ YES ❑ NO | |
| PHYSICIAN NAME | |
| SPECIALTY | |
| HAVE ANY LEGAL CLAIMS BEEN FILED RELATED TO YOUR PAIN? | |
| ❑ YES ❑ NO | |

| PLEASE INDICATE YOUR EMPLOYMENT STATUS: | | |
|---|---|---|
| ❑ UNEMPLOYED BECAUSE OF PAIN | ❑ ON DISABILITY | ❑ EMPLOYED, PART-TIME |
| ❑ UNEMPLOYED BUT LOOKING FOR WORK | ❑ RETIRED | ❑ EMPLOYED, FULL-TIME |
| ❑ HOMEMAKER | ❑ OTHER: | |
| JOB DESCRIPTION | | |
| | | |

| ARE YOU TAKING ANY OF THE FOLLOWING? |
|---|
| ❑ COUMADIN (WARFARIN) |
| ❑ PRADAXA (DABIGATRAN) |
| ❑ XARELTO (RIVAROXABAN) |
| ❑ PLAVIX (CLOPIDOGREL) |
| ❑ LOVENOX (ENOXAPARIN) |
| ❑ ASPIRIN |
| ❑ AGGRENOX |
| ❑ BRILINTA |
| ❑ TICLID |
| ❑ OTHER BLOOD THINNER? |

| WHY: | |
|---|---|
| PRESCRIBING PHYSICIAN: | |