

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Primary Care Physician: _____ Referring Physician _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Do you smoke? **YES NO**

Are you latex sensitive? **YES NO**

Do you have a pacemaker? **YES NO**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Have you **RECENTLY** noted any of the following (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> fainting |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> cough |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> headaches |
| <input type="checkbox"/> falls | <input type="checkbox"/> changes in bowel or bladder function | |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> constipation | |
| <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> diarrhea | |

Have you **EVER** been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chest pain/angina | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Other arthritic condition | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bladder/urinary tract infection | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eye irritation/infection | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Sexually transmitted disease/HIV | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Recent Infection | <input type="checkbox"/> Incontinence | |

During the past month have you been feeling down, depressed or hopeless? **YES NO**

During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

- | | | |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

ALLERGIES: List any medication(s) that you are allergic to: _____

Have you had any of the following for your current problem: X-Ray Injection MRI CT Scan

Have you received Home Health Therapy for this problem? **YES NO** If yes, Date of last visit _____

Are you currently being treated by a chiropractor? **YES NO**

Date of Injury or Surgery _____ Body Part Affected _____

Are you on a work restriction from your doctor? **YES** **NO**

What do you think caused your symptoms? _____

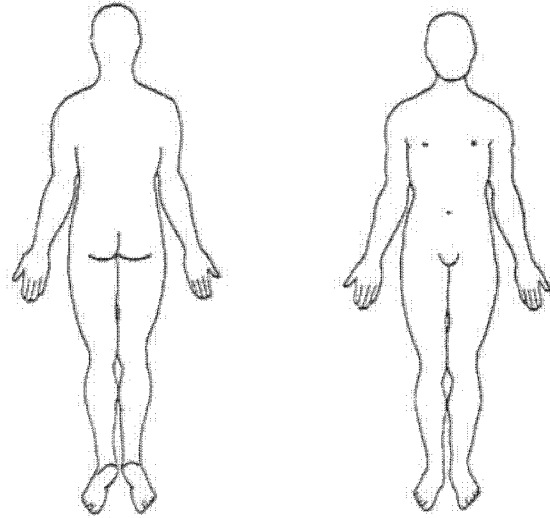
Have you ever had this problem before? **YES** **NO** When _____ Treatment rec'd _____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ Shooting/sharp pain
- Dull/aching pain
- ξξξξ Numbness
- = Tingling



My symptoms currently: Come and go Are Constant Are constant, but change with activity

Aggravating Factors: identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

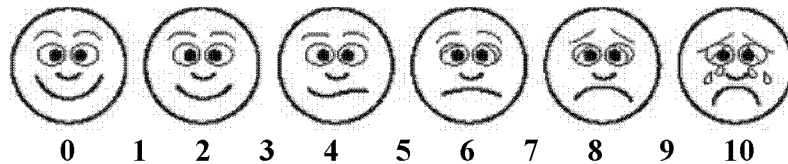
How are you currently able to sleep at night due to your symptoms?

- No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms **worst**? Morning Afternoon Evening Night After exercise

When are your symptoms the **best**? Morning Afternoon Evening Night After exercise

Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:



Your **CURRENT** level of pain while completing this survey: _____

The **BEST** your pain has been during the **past 24 hours**: _____

The **WORST** your pain has been during the **past 24 hours**: _____

Name: _____