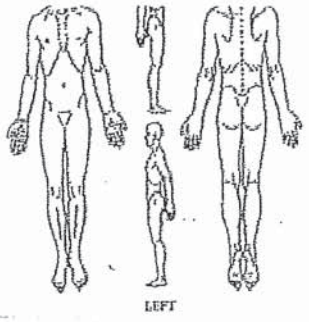
Advanced Back Pain & Injury Center

Beyond mere relief – back to full activity fast



Please mark your area of pain

History of Illness / Injury / Pain

Name _____ Date_____

Chief Complaint and its location: _____

_____

What caused the onset?_____

What makes it better? _____

What makes it worse?_____

Describe the pain i.e. - ❑ achy ❑ burning ❑ sharp ❑ dull ❑ stabbing ❑ throbbing ❑ numbness

❑ Other _____

Does the pain radiate? ❑ Yes ❑ No Where? _____

On a scale of 1-10, what would you rate your pain? Please circle 1 2 3 4 5 6 7 8 9 10

How much of your day do you feel the pain? ❑ All Day ❑ Half of the Day ❑ Quarter of the Day

❑ Other _____

What time of the day do you feel it the most? _____

Have you lost work days because of it? ❑ Yes ❑ No How Many? _____

Was it caused by and Automobile Accident ❑ Yes ❑ No Work Related ❑ Yes ❑ No

❑ Other _____

Have you experienced the pain in the past? ❑ Yes ❑ No How long ago _____

Have you been treated by a chiropractor for this or any other condition? ❑ Yes ❑ No If yes, by whom? _____ How long ago? _____

Were you helped? ❑ Yes ❑ No Did you follow the Dr's recommendations? ❑ Yes ❑ No Are you currently being treated by another doctor? ❑ Yes ❑ No If yes, by whom? _____

Why were you being seen? _____

Please list current medications you are currently taking, including over-the-counter and prescription medications _____

Secondary Complaints Please Describe

1. _____ _____

On a scale of 1-10, what would you rate your pain? Please circle 1 2 3 4 5 6 7 8 9 10

2. _____ _____

On a scale of 1-10, what would you rate your pain? Please circle 1 2 3 4 5 6 7 8 9 10

3. _____ _____

On a scale of 1-10, what would you rate your pain? Please circle 1 2 3 4 5 6 7 8 9 10

4. _____ _____

On a scale of 1-10, what would you rate your pain? Please circle 1 2 3 4 5 6 7 8 9 10

How do you want us to handle your condition?

❑ Maximum Correction (Correct the cause of the problem, so it doesn't return)

❑ Temporary Relief (Pain relief from symptom, no correction)

How did you hear about our office?_____

_____How committed are you to reaching your maximum health potential?

_____How important is it for your family to be at their maximum health potential?

_____How committed are you to preventing arthritis and maximizing your spinal stability?

Systems Review: Please place an ***X*** in the blank area if you are experiencing symptoms NOW and a ***P*** if you have experienced in the PAST:

_____Alcoholism	_____Ear problems	_____Muscle weakness
_____Allergies	_____**Eating disorder	_____Nausea
_____Anxiety	_____Eye/Vision Problems	_____Neck Pain
_____**Arthritis	_____Fatigue	_____Nervousness
_____Asthma/Wheezing	_____**Female problems	_____Numb/Tingle Hands
_____Bed-wetting	_____Frequent sore throat/Strep	_____Numb/Tingle Foot
_____Blood in urine/stool	_____Gall Bladder	_____Pacemaker
_____**Broken/fractured bones	_____Headache	_____Pain: Hips/Legs/Feet
_____**Cancer	_____**Heart Problems	_____Knee Pain RT LT
_____Circulatory problems	_____ Heartburn/Gas	_____Rib/Chest Pain
_____Cold feet/hands	_____Hiatal Hernia	_____Shoulder Pain RT LT
_____Confusion	_____High/Low Blood Pressure	_____**Prostate Problems
_____**Congenital Disease	_____HIV Positive	_____Recurrent Bladder Infections
_____Constipation	_____Indigestion	_____Recurrent Kidney Infections
_____Cramping of legs/feet	_____Insomnia	_____Recurrent lung Infections
_____Depression	_____Irregular Heartbeat/Palpitations	_____Seizures/Convulsions
_____**Diabetes	_____Irritability	_____Sexual Dysfunction
_____Diarrhea	_____Kidney Stones	_____**Skin Problems
_____Difficulty breathing	_____Liver trouble	_____Stroke
_____**Digestive problems	_____Loss of Bladder Control	_____Ulcers
_____Dizziness/Fainting/Vertigo	_____Loss of Memory	_____Weakness in Grip RT LT
_____Drug addiction	_____Mid Back Pain	_____Other:_____

***EXPLAIN**:_____

_____

_____

Women Only:

_____Currently Pregnant

_____Excessive Flow

_____Hot Flashes

_____Hysterectomy

_____Irregular Periods

_____Lumps in Breast

_____Menstrual Cramps

_____PMS/Menopause

_____Other:_____

Men Only:

_____Difficulty with Urination

_____Erectile Dysfunction

_____Prostate trouble

_____Testicular Cancer

_____Other:_____

Family History: Please check those that have affected you or your family. Who?_____

_____Anemia	_____Developmentally Challenged	_____High Blood Pressure
_____Asthma	_____Diabetes	_____Kidney Disease
_____Cancer	_____Epilepsy	_____Low Blood Pressure
_____Circulatory Problems	_____Heart Disease	_____Obesity
_____Psychiatric	_____Stroke	_____Tuberculosis

_____Other:_____

Social History:

Smoke: Yes No Amount per day:_____

Exercise: Yes No Please describe:_____

Drink (please check all that apply): Coffee_____ Tea_____ Alcohol_____ Soda_____

Describe regularity of all checked:_____

Do you sometimes feel that you do not have enough energy to get through the day? Yes___ No_____

Do you take nutritional supplements? Yes_____ No_____ Describe:_____

Are you on any special diet? Yes_____ No_____ Describe:_____

Thank you for completing this questionnaire.

This information is necessary in evaluating your condition. I authorize the release of any information required, and that my Insurance benefit payments be paid directly to the clinic. Signature states all to be true.

Patient / Guardian Signature:_____

Date:_____