

18. Rate the severity of your pain
Least pain - 1 2 3 4 5 6 7 8 9 10 - Severe
19. How often do you have this pain? _____
 constant comes & goes other
20. Does it interfere with your
 work sleep recreation Daily routine
 other _____
21. Activities or movements that are painful to perform sitting standing walking
 lying down other _____

22. Is the condition worse at certain times of the day?
 morning Evening
 other _____
23. Does the problem/condition refer anywhere?
(ex: into right arm) _____
24. What have you done for the problem/condition?
(ex: used ice/heat) _____

- Is it helping? Yes No

Health History & Other Past or Present Concerns (Please circle YES or NO)

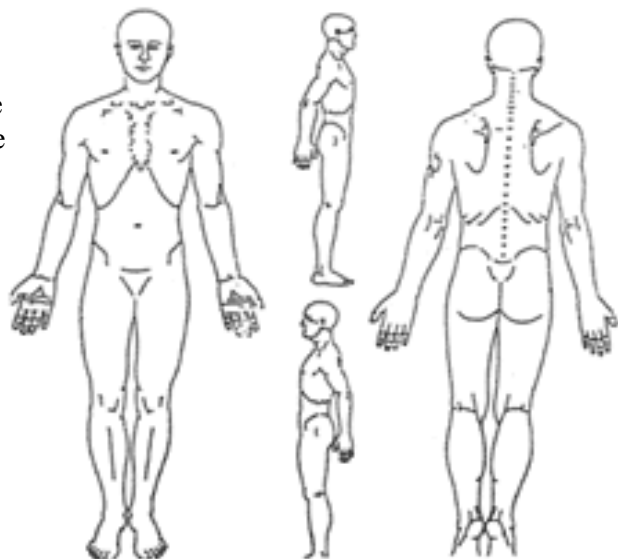
- | | | | |
|---------------------------|-------------------------|---------------------------|-------------------------|
| Arthritis Yes No | Diabetes Yes No | Kidney disease Yes No | Prosthesis Yes No |
| Asthma Yes No | Diarrhea Yes No | Liver disease Yes No | Pins and Needles Yes No |
| Anemia Yes No | Depression Yes No | Loss of Balance Yes No | Stroke Yes No |
| Allergy Shot Yes No | Emphysema Yes No | Loss of Smell Yes No | Stress Yes No |
| Anorexia Yes No | Epilepsy Yes No | Loss of Taste Yes No | Thyroid Problems Yes No |
| Alcoholism Yes No | Ear Ring Yes No | Loss of Memory Yes No | Tonsillitis Yes No |
| AIDS/HIV Yes No | Fractures Yes No | Migraines Yes No | Tuberculosis Yes No |
| Bronchitis Yes No | Fainting Yes No | Miscarriage Yes No | Tension Yes No |
| Bleeding Disorders Yes No | Fatigue Yes No | Multiple Sclerosis Yes No | Ulcers Yes No |
| Back Discomfort Yes No | Fever Yes No | Nervousness Yes No | Visual Problems Yes No |
| Cancer Yes No | Glaucoma Yes No | Neck Stiffness Yes No | Whooping Cough Yes No |
| Cataracts Yes No | Gout Yes No | Numbness Yes No | Prostate Problem Yes No |
| Chest Pains Yes No | Heart Disease Yes No | Osteoporosis Yes No | Other: _____ |
| Cold Hands Yes No | Hernia Yes No | Pacemaker Yes No | _____ |
| Constipation Yes No | Herniated Disk Yes No | Parkinson's Yes No | _____ |
| Cold Sweats Yes No | High Cholesterol Yes No | Pinched Nerves Yes No | _____ |
| Cold Feet Yes No | Headaches Yes No | Pneumonia Yes No | _____ |
| Dizziness Yes No | Irritability Yes No | Prostate Problem Yes No | |

Past Medical/Accident History (Please Give Details)

- Have you ever been diagnosed with any medical condition? _____
- Have you been under drug and medical care? _____
- List all accidents (Minor and Major)? _____
- List all fractures/Surgery or Other? _____

Pain Diagram

Please Circle your Problems and indicate the type of pain on the diagram to the right:



Ache = AAA

Numbness = NNN

Pins & Needles = OOO

Burning = XXX

Stabbing = ///

Exercise

- None Moderate Daily Heavy

Work Activity

- Sitting Standing Light labor Heavy labor

Diet

- Excellent Good Poor

Habits

- Smoking
 Alcohol
 Caffeine/Coffee
 Stress
 Fast Food

- Packs/Day _____
Drinks/Week _____
Cups/Day _____
Reason _____
Times/Week _____

The above information is true and accurate to the best of my knowledge.

Patient Signature _____

Date _____