PATIENT HISTORY

Work Related? Yes No Motor vehicle accident? Yes No

Are you currently working? Yes No What kind of job?_____

Have you had any of the following medical tests? X-rays CT Scan MRI

Arthrogram Discogram Injections Bone Density Test/Scan Blood Tests

EMG/NCV Other _____ Date of test_____

Results: _____

_____

Are you presently taking any of the following medications? Anti-inflammatories

Pain Pills Muscle relaxers Hormone replacement Blood thinners

Insulin Other _____

Have you had treatment in the past for this problem? Yes No Injections

Chiropractic Physical therapy/occupational If yes, what and did it help?

_____

_____

Have you been pregnant? Yes No N/A Number of pregnancies? _____

My pain is constant/intermittent. What makes the pain worse? Sitting Walking

Standing Reaching Looking up Bending Breathing deeply Lifting Repetitive motions

Squatting Stairs Other _____

Pain rating: Lowest 0 1 2 3 4 5 6 7 8 9 10 Highest

What makes the pain better?

Medicine Ice Heat

Rest Changing positions

Other: _____

Does your problem prevent you from sleeping?

Yes No

Can you lay on the affected side?

Yes No

Any dizziness?

Yes No

Any numbness or tingling?

Yes No

Any Headaches?

Yes No

Do you have an attorney for this problem?

Yes No

Who?_____

Where's your pain?