

**Macintosh HD:Users:laureneuston:Desktop:Screen Shot 2018-01-30 at 1.37.54 PM.png**

**NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. Describe the DATE and precisely HOW your current pain began. (Brief history of reason for visit)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_

**2. What is your current OCCUPATION?**

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical Duties:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Employment Status:**

* Regular Duty
* Light Duty
* Terminated
* Disabled
* Retired
* New Occupation
* Out of work over past \_\_\_\_months

**3. My pain is INCREASED by:** (Check all that apply)

\_\_\_bending/twisting your neck

\_\_\_working overhead

\_\_\_bending my back

\_\_\_lifting

\_\_\_twisting torso/lower back

\_\_\_standing for a while

\_\_\_sitting for a while

\_\_\_coughing

\_\_\_sneezing

\_\_\_lying in bed

**4. My pain is DECREASED by:** (Check all that apply)

\_\_\_rest

\_\_\_heat

\_\_\_lying down

\_\_\_lying on my side

\_\_\_brace

\_\_\_medications

\_\_\_stretching

\_\_\_nothing

**5. PRIOR “SPINE” HISTORY: If you have had any history of neck or low back pain in the past, please describe and when.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. List the PHYSICIANS who have evaluated your current condition. 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7. List any TREATMENTS that you have had for your *CURRENT* condition we are seeing you for.**

\_\_\_**None**

\_\_\_**Physical therapy**

Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_**Chiropractic**

Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_**Medications**

What\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_**Epidural steroid injections**

Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_**Other(explain)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_**PRIOR SPINE SURGERY? (When,What, Dr’s Name)**

**1**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. What TESTS have been completed prior to your visit?**

\_\_\_none \_\_\_X-Rays

\_\_\_CT Scan \_\_\_MRI Scan

\_\_\_nerve studies(“EMG”) \_\_\_myelogram

**9. Please complete the PAIN DRAWING below*. (****Shade areas of pain and star areas of numbness)*



**10. Your MEDICAL HISTORY: (i.e. high blood pressure, history of heart attack, stroke, cancer, etc)**

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11. Your SURGICAL HISTORY: (list any prior surgeries you’ve had in any area)**

***(For office use only)***

**PHYSICAL EXAM:**

Gait:

ROM:

Motor:

Sensory:

Reflexes:

SLR/Spurlings:

Hoffmans/Clonus:

Related joint:

Peripheral Nerve:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MRI’s**

**Cervical( ) Lumbar( )**

1-2 L1-2

2-3 2-3

3-4 3-4

4-5 4-5

5-6 5-1

6-7 S1-2

7-1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**XRAYS/RADIOGRAPHIC STUDIES**

Cervical:

Thoracic:

Lumbar:

Other Studies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMPRESSION(S):**

1)

2)

3)

4)

5)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLAN**:

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12. Your current MEDICATION LIST:**

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13. Your DRUG OR MEDICATION ALLERGIES/REACTION:**

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**14. Your SOCIAL HISTORY:**

**I am currently**

\_\_\_Single

\_\_\_Married

\_\_\_Divorced

\_\_\_Widow/Widower

**I am currently**

\_\_\_Unemployed

\_\_\_Employed

\_\_\_Retired

\_\_\_Disabled

**Do you use ALCOHOL?**

\_\_No \_\_infrequent \_\_weekly \_\_daily

**Do you SMOKE?**

\_\_Yes \_\_No \_\_Former smoker for \_\_ years

**If there is any history of DRUG OR ALCOHOL ABUSE, please describe.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**15. Is there any ATTORNEY involved in this case? If yes, please list name. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**16. REVIEW OF SYSTEMS/MYELOPATHIC?**

(Please check all that apply)

\_\_Chest Pain \_\_Visual Changes

\_\_Difficulty swallowing \_\_Feel off balance walking

\_\_Shortness of breath \_\_Tripping/stumbling/falling

\_\_Heartburn/Reflux \_\_Loss of hand coordination

\_\_Dizziness \_\_Complete loss of Bowels control

\_\_Abdominal pain \_\_Handwriting changes

\_\_Headaches \_\_Complete loss of Bladder control

**AGE**\_\_\_\_\_\_\_\_ **HT**\_\_\_\_\_\_\_\_\_ **WT**\_\_\_\_\_\_\_\_\_

***To the best of my knowledge, the questions on this form have been answered correctly. I understand that providing incorrect answers can be dangerous to my health. It is my responsibility to inform the doctor’s office of any changes in my medical status. I authorize the healthcare staff to perform necessary services that I may require.***

**Patient Signature Date**