

NAME _____

TODAY'S DATE ____/____/____

DATE OF APPOINTMENT ____/____/____

Please list the top three questions you would like answered during today's visit:

1. _____
2. _____
3. _____

1. How and when did your problem begin? (Mark each that applies):

- | | |
|---|---|
| <input type="checkbox"/> I don't know how it began. | <input type="checkbox"/> work related injury |
| <input type="checkbox"/> It comes and goes. | <input type="checkbox"/> injury related to a motor vehicle accident |
| <input type="checkbox"/> I've had it a long time | <input type="checkbox"/> sports related injury |
| <input type="checkbox"/> Injury (date of injury _____) | <input type="checkbox"/> unrelated to any particular incident |

2. Please list previous back, neck, and/or joint problems:

3. Have you or will you file a Workers' Compensation or No-Fault Insurance Claim? YES NO
 Is this injury related to a motor vehicle Accident? YES NO
 Do you currently have an open auto insurance claim for this injury? YES NO

4. At any point in time, have you had a Workers' Compensation or No-Fault Claim? YES NO
 What of your body was/is involved: _____

5. What is your occupation? _____

6. Are you currently working? YES NO With? Regular Duty Modified/Light Duty

7. Date last worked: ____/____/____

8. Check which of the following activities change the nature of our pain, if applicable:

	Aggravates Pain	Relieves Pain		Aggravates Pain	Relieves Pain
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	Lying on your back	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	Lying on your stomach	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	Driving	<input type="checkbox"/>	<input type="checkbox"/>
Rising from sitting	<input type="checkbox"/>	<input type="checkbox"/>	Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>
Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: _____ DOS: _____

9. List all physicians you have consulted for your present condition:

10. Have you had any of the following studies? (Please check)

- | | | | |
|--|--------------------------|---------------------------------------|--------------------------|
| <input type="checkbox"/> Plain X-rays | Date: _____ Where: _____ | <input type="checkbox"/> Myelogram | Date: _____ Where: _____ |
| <input type="checkbox"/> CT scan | Date: _____ Where: _____ | <input type="checkbox"/> Discogram | Date: _____ Where: _____ |
| <input type="checkbox"/> MRI | Date: _____ Where: _____ | <input type="checkbox"/> Bone scan | Date: _____ Where: _____ |
| <input type="checkbox"/> EMG(nerve test) | Date: _____ Where: _____ | <input type="checkbox"/> Bone density | Date: _____ Where: _____ |
| <input type="checkbox"/> Other _____ | Date: _____ Where: _____ | (DEXA) | |

11. Have you had any of the following for your current problem? If Yes, did it make your condition better or worse?

- NSAID Therapy Better Worse; When(if within past 6months)? _____
List(Aleve, Motrin, Celebrex, etc)? _____
- Physical Therapy Better Worse; When? _____ Where? _____
- Chiropractic Care Better Worse; When? _____ Where? _____
- Steroid Injection Better Worse; When? _____ Where? _____
- Other: _____ Better Worse; When? _____ Where? _____

12. Have you had previous spine surgery for your current pain or problem?

Type of surgery _____ Date _____ Surgeon _____

Did it make your pain: Better Worse _____

13. Please check whether or not you have had the following problems:

- | YES | NO | YES | NO |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> | <input type="checkbox"/> Bronchitis/Emphysema | <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> | <input type="checkbox"/> Heart disease or heart attack | <input type="checkbox"/> | <input type="checkbox"/> Kidney Infections |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatic disease, Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Prostatic problems |
| <input type="checkbox"/> | <input type="checkbox"/> High blood pressure | | |

14. Please list any other medical problems not listed above: _____

15. Are you taking medications for medical conditions? Please list or see attached: _____

16. Are you allergic to any medications? YES NO (If Yes, please list)

Have you ever had x-ray dye? YES NO

Are you allergic to x-ray dye? YES NO

Patient Name: _____ DOS: _____

17. List all previous surgeries:

_____	Year: _____	_____	Year: _____
_____	Year: _____	_____	Year: _____
_____	Year: _____	_____	Year: _____

18. Please check whether or not you have had the following problems:

YES	NO		YES	NO			
<input type="checkbox"/>	<input type="checkbox"/>	Change in ability to pass urine	1	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with bowel movements	2	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss	3	<input type="checkbox"/>	<input type="checkbox"/>	Loss of consciousness	
<input type="checkbox"/>	<input type="checkbox"/>	Night pain		<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	
<input type="checkbox"/>	<input type="checkbox"/>	Fever		<input type="checkbox"/>	<input type="checkbox"/>	Swelling of toe or finger joints	
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty falling asleep		<input type="checkbox"/>	<input type="checkbox"/>	Headaches	
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty staying asleep	4	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	8
<input type="checkbox"/>	<input type="checkbox"/>	Feeling tired in the morning		<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat or palpitations	9
<input type="checkbox"/>	<input type="checkbox"/>	Visual changes	5	<input type="checkbox"/>	<input type="checkbox"/>	Rashes or blisters	10
<input type="checkbox"/>	<input type="checkbox"/>	Weakness	6				
<input type="checkbox"/>	<input type="checkbox"/>	Numbness	7				
		Poor coordination:					
<input type="checkbox"/>	<input type="checkbox"/>	With gait					
<input type="checkbox"/>	<input type="checkbox"/>	With fine hand manipulations					
<input type="checkbox"/>	All other systems negative						

19. Are you currently: Single Married Divorced Separated Widowed

20. Do you smoke cigarettes? NO YES _____ packs per day x _____ years
Are you trying to quit smoking? NO YES

21. Do you drink alcoholic beverages? NO YES How much per week? _____

22. If your symptoms were better, what two physical activities would you like to do better or return to doing?

23. Currently (or before symptoms began), what regular exercises were you doing?
(examples: running, weight training)

1. _____	2. _____
3. _____	4. _____

Ethan Colliver, DO: _____
Thomas DiCarlo, MD: _____