

Name \_\_\_\_\_ Date \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_

1 - For what condition / symptoms are you being seen at this time?

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

2 - When did it start (give approximate date) ? \_\_\_\_\_

3 - How did it start? (If accident or injury, please describe the incident). \_\_\_\_\_

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

4 - Please give a step by step history of the progression of symptoms from onset to the present. When possible, give approximate dates of important changes or developments.

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

5 - Do you have back pain? \_\_\_\_\_

6 - Do you have leg pain? \_\_\_\_\_

If so, right, left or both? \_\_\_\_\_

If both, which side is worse? \_\_\_\_\_

7 - Do you have neck pain? \_\_\_\_\_

8 - Do you have arm or shoulder pain? \_\_\_\_\_

If so, right, left or both? \_\_\_\_\_

Which side is worse? \_\_\_\_\_

9 - Please describe your pain, including activities which help or make it worse. \_\_\_\_\_

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

	Yes	No
Coughing	( )	( )
Bending	( )	( )
Lifting	( )	( )
Sitting / Driving	( )	( )
Standing	( )	( )

10 - Do you have numbness or tingling? \_\_\_\_\_ Where? \_\_\_\_\_

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

11 - Do you have weakness? \_\_\_\_\_ Where? \_\_\_\_\_

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

12 - Do you have any bladder control problems? \_\_\_\_\_

13 - Do you have any bowel control difficulties? \_\_\_\_\_

14 - Employer \_\_\_\_\_

What do you do? \_\_\_\_\_

How does this affect your back? \_\_\_\_\_

What activities can you not do that your job requires you to do? \_\_\_\_\_

\_\_\_\_\_

15 - Have you ever been in a hospital for back, leg, neck, or arm pain? \_\_\_\_\_

Dates \_\_\_\_\_

16 - Have you ever had a myelogram (X-ray of the spine with dye injection)? \_\_\_\_\_

Dates \_\_\_\_\_ Who ordered it? \_\_\_\_\_

18 - Have you ever had an MRI? \_\_\_\_\_ Dates \_\_\_\_\_

Who ordered it? \_\_\_\_\_

19 - Have you ever had an EMG? \_\_\_\_\_ Dates \_\_\_\_\_

20 - Do you exercise on a regular basis? \_\_\_\_\_

21 - What is your weight? \_\_\_\_\_

22 - What other doctors or chiropractors have you seen for this condition? \_\_\_\_\_

When \_\_\_\_\_

Where? \_\_\_\_\_

23 - Have you ever had surgery on your back or neck? \_\_\_\_\_

Dates and type of surgery done? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

24 - What treatments have you had?

Where

When

Chiropractic: \_\_\_\_\_

Physical Therapy: \_\_\_\_\_

Pain Management: \_\_\_\_\_

25 - Please list medications you have taken for pain or spasm during the past year, and include dose and number taken per day?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

