INITIAL HISTORY

Name: ____D.O.B._____/______/_______

Please provide the following information to the best of your ability.

Please describe your accident/injury or history of problem in detail:

____
____
____

When did your condition begin? _________________ **Have your symptoms gotten…** Worse Better Same (circle only one)

Have you had these symptoms before? If so, how many times? __________

Your current symptoms are… Constant Intermittent Worse in the… A.M. P.M. **Are you:** Right-Handed Left-Handed

If intermittent, how long do the episodes last? ____________ **How frequent are the episodes?** ___________

What activities increase your pain? (circle those that apply)

Sitting - Standing - Walking - Lifting – Housework - Coughing/Sneezing - Lying flat on back - Lying flat on stomach

Anything else that aggravates the symptoms?____

What activities decrease your pain? (circle those that apply)

Sitting - Standing - Walking - Lying flat on back - Lying flat on stomach

Anything else that aggravates the symptoms?____

Do you have any <u>pain</u> going down your arm or leg? No Yes (if "yes" circle the area involved) **R** Arm - **L** Arm - **R** Leg - **L** Leg

Do you have <u>numbness/tingling</u> down your arm or leg? No Yes (if "yes" circle the area involved) **R** Arm - **L** Arm - **R** Leg - **L** Leg

Do you have <u>weakness</u> of your arm or leg? No Yes (if "yes" circle the area involved) **R** Arm - **L** Arm - **R** Leg - **L** Leg

Is the pain… sharp, dull, sore, deep, superficial, shooting, stabbing, gnawing, burning (circle all applicable)

Do you have difficulty sleeping because of pain? Yes No

Is there a specific time of day your symptoms are worse? Yes No If yes, please explain______________________________________

Have any other health care providers evaluated you for this problem? Yes No

If yes, who/when?____

Have you had any tests (x-rays, CT scan, MRI) to evaluate this problem? Yes No

If yes, please describe test and the facility performed:____

What treatments have you received? Please describe (ex: PT, Chiro, Surgery)

______________________________ Made Better Worse No Change (Circle One)

______________________________ Made Better Worse No Change (Circle One)

______________________________ Made Better Worse No Change (Circle One)

Have you had <u>any</u> previous accident or injury? Yes No

If yes, please describe where and when ____

Please list all prescription medications, OTC meds and supplements you are taking.

Name	For how long?	Side effects?

INITIAL HISTORY

Name: ____ D.O.B._____/______/_______

Past Medical History

Please circle the "Yes" or "No" box if you have any of the following illnesses

Diabetes	No	Yes	Thyroid problems	No	Yes
Hypertension/High Blood Pressure	No	Yes	Allergy problems	No	Yes
Heart Disease	No	Yes	High Cholesterol	No	Yes
Kidney/Bladder/Prostate problems	No	Yes	Neurological problems	No	Yes
Respiratory Issues	No	Yes	Addiction/Substance Abuse	No	Yes
Stomach/Intestinal	No	Yes	Mental Health/Psychiatric	No	Yes
Bleeding Disorder	No	Yes	Other medical diagnosis	No	Yes

For any yes answers, please explain____

Please list all surgeries.

Type of Surgery	When & Name of Surgeon

Review of systems: Please check the "Yes" or "No" box if you have any of the following symptoms.

		Yes	No		Yes	No
GENERAL	Chills	( )	( )	Weight Loss or Gain	( )	( )
	Fatigue	( )	( )	Daytime Sleepiness	( )	( )
ALLERGY	Environmental	( )	( )	Sneezing fits	( )	( )
NEURO	Passing out	( )	( )	Seizures	( )	( )
	Weakness	( )	( )	Numbness/tingling	( )	( )
	Memory Loss	( )	( )	Abnormal ache	( )	( )
EYES	Eye pain	( )	( )	Vision Changes	( )	( )
ENT	Ringing in ears	( )	( )	Dizziness	( )	( )
	Hearing loss	( )	( )	Sinus pain	( )	( )
	Snoring	( )	( )	Sore throat	( )	( )
RESPIRATORY	Cough	( )	( )	Coughing Blood	( )	( )
	Wheezing	( )	( )	Shortness of Breath	( )	( )
CARDIAC	Chest Pain	( )	( )	Palpitations	( )	( )
	Wake short of breath	( )	( )	Ankle Swelling	( )	( )
GASTROINTESTINAL	Trouble swallowing	( )	( )	Heartburn	( )	( )
	Abdominal Pain	( )	( )	Nausea/Vomiting	( )	( )
	Bowel Irritability	( )	( )	Rectal Bleeding	( )	( )
GENITOURINARY	Frequent Urination	( )	( )	Painful Urination	( )	( )
	Blood in urine	( )	( )	Prostate Problems	( )	( )
	Loss of bladder	( )	( )	Could you be pregnant?	( )	( )
HEME/LYMPTH	Swollen glands	( )	( )	Sweating at night	( )	( )
	Bleeding	( )	( )	Easy Bruising	( )	( )
ENDOCRINE	Feel warmer	( )	( )	Feel cooler than others	( )	( )
MUSCOLOSKEL	Joint pain	( )	( )	Cramps	( )	( )
	Muscle Ache	( )	( )	Weakness	( )	( )
	Loss of mobility	( )	( )			
DERM-	Rash	( )	( )	Hives	( )	( )
ATOLOGIC	Itching	( )	( )	Skin or Hair changes	( )	( )
MENTAL HEALTH	Nervousness	( )	( )	Tension	( )	( )
	Mood changes	( )	( )	Depression	( )	( )

MN SPINE AND SPORT
MOVE BETTER. FEEL BETTER. LIVE BETTER.

INITIAL HISTORY

Name: ____D.O.B._____/______/_______

Anxiety/Panic	( )	( )

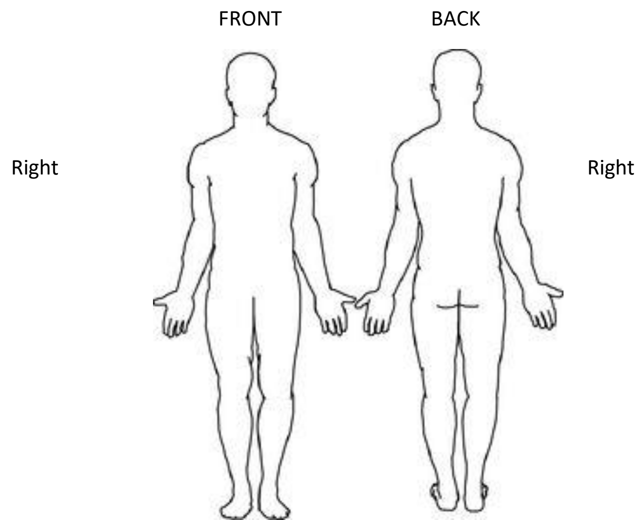
Family History: Please check the "Yes" or "No" box if any relatives have/had any of the following illnesses. If yes, please indicate which relative(s) have/had the problem.

	No	Yes	
Back Problems	( )	( )	______________________________
Rheumatoid Arthritis	( )	( )	______________________________
Heart problems/murmurs	( )	( )	______________________________
Diabetes	( )	( )	______________________________
Cancer	( )	( )	______________________________
Bleeding Disorder	( )	( )	______________________________

Are you currently: (Circle One) Single Married Widowed Divorced Separate
How many children do you have? _______ **Ages?** ___________ **How many live with yo**u? __________
Do you smoke cigarettes? Yes No **Packs per day:** ____________
Do you drink alcoholic beverages? Yes No **How many drinks per day?** _______________
Do you take or have you ever used any street drugs (ex-marijuana, cocaine, etc.)? Yes No
Are you working? Yes No Full-Time Part-Time
When did you last work? Date: ________ **Is there light duty available at work?** Yes No
Occupation and job duties: (ex: sitting at a computer, lifting, bending, twisting, etc.) ____
Do you enjoy your work? Yes No **Do you like your co-workers?** Yes No
What hobbies or activities (work, sports, and hobbies) do you hope to return? ____

PAIN DRAWING

INSTRUCTIONS: Mark these drawings according to where you hurt (if the back of your neck hurts, make the drawing on the back of the neck, etc.). If you feel any of the following symptoms, please indicate which sensations you feel by placing the marks shown below.



PAIN LEVEL: (Circle one)

0	1 2 3	4 5 6	7 8	9 10
(No Pain)	(tolerate pain w/o meds)	(requires medication)	(go to ER)	(severe pain-go to the hospital)