

Name: _____ SSN: _____ Date: _____

My overall health is: Excellent __ Good __ Fair __ Poor __:

Occupation, or activities that comprise your day: _____

Age: _____ Height: _____ Weight: _____

Are you able to work? Y/N Do you have any restrictions from your doctor? Y/N Please explain _____ Are you latex sensitive? Y/N

Do you smoke? Y/N How much _____ Do you have a pacemaker? Y/N

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Y/N

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- | | | |
|--|---|---|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> constipation |
| <input type="checkbox"/> fever/chills/sweats: When _____ | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> dark stool/ bleeding |
| <input type="checkbox"/> weight loss/gain How much _____ | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> fainting | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough |
| <input type="checkbox"/> falls How Many _____ | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> headaches |

For Therapist use only: _____

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> lung problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> other arthritic condition | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke | <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> bone or joint infection | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> pneumonia |

For Therapists use only _____

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots |

During the past month have you been feeling down, depressed or hopeless? Y/N

During the past month have you been bothered by having little interest or pleasure in doing things? Y/N

Is this something with which you would like help? Y/N YES, BUT NOT TODAY N

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? Y/N

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? Y/N

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: Getting Better Getting Worse Staying about the same

I should not do physical activities that might make my pain worse: Disagree Unsure Agree

Treatment received so far for this problem (chiropractic, injections, etc) _____

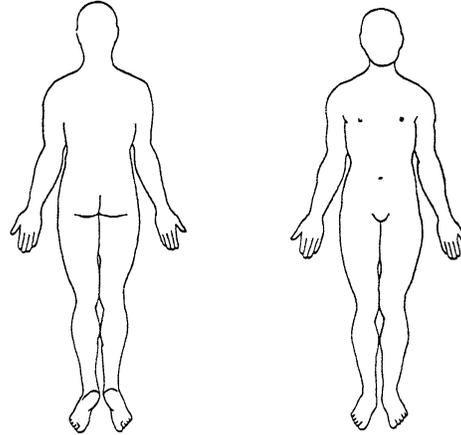
Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: Yes No When _____ Treatment rec'd _____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:



- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling

My symptoms currently: Come and go Are Constant Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

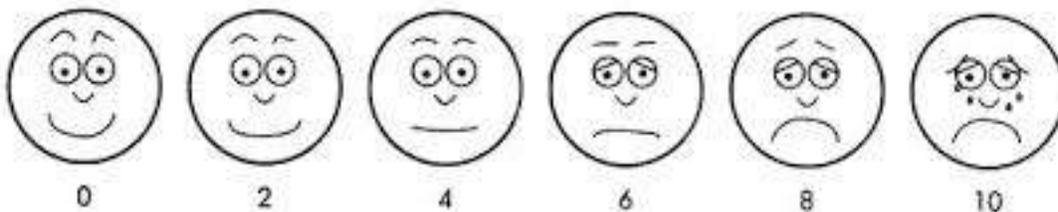
1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms the best? Morning Afternoon Evening Night After exercise



Your current level of pain while completing this survey: _____ The best your pain has been during the past 24 hours: _____ The worst your pain has been during the past 24 hours: _____