Name: _____ Date: _____

Home Address: _____

Email Address: _____

Phone Numbers (H) _____ (W) _____

(Cell) _____ Referred by: _____

SS#: _____ Age: _____ Birth Date: _____/_____/_____

Type of Injury: ( ) W/C ( ) Auto ( ) Other: _____

Date of Injury/Onset: _____

Employer at time of injury (if W/C): _____

Please describe how you were injured: _____

_____

_____

STAFF USE ONLY

HT:

WT:

Handed: R L

BP:

PULSE:

What treatment have you received since the injury or onset of pain?

( ) Hospital/Emergency Room: _____

Date(s) of treatment: _____, _____, _____, _____

Medications: _____

Tests/Treatment: _____

( ) Medical/Surgical Doctor(s): _____

Dates of treatment: From _____to _____ Type of treatment: _____

_____

Medications: _____

_____

( ) Chiropractic Doctor(s): _____

Dates of treatment: From _____ to _____ Type of Treatment: _____

_____

( ) Physical Therapy Location(s): _____

Dates of treatment: From _____to _____ Type of treatment: ____

_____

What test(s) have you had for <u>this</u> condition?

TEST DATE BODY PART WHERE_

_____

_____

_____

_____

What operation(s) have you had for <u>this or any</u> other condition?

DATE OPERATION SURGEON RESULTS

_____

_____

_____

Current Complaint(s): _____

_____

_____

Have you ever had this problem before? YES NO When? _____
Please explain: _____
What makes your pain better? _____
What makes your pain worse? _____
Do you have trouble holding your bowel or bladder? NO YES Which? _____
Does coughing or sneezing effect your pain? NO YES Which?: _____
If yes, where is your pain increased? _____

PAST MEDICAL HISTORY: (P) = Personal (You); (F) = Your Family - Please circle all that apply:

Arthritis (P) (F)	Heart Problems (P) (F)	Seizures (P) (F)
Asthma (P) (F)	Stroke (P) (F)	Menstrual Problems (P) (F)
Bladder problems (P) (F)	Hepatitis (P) (F)	Erection Problems (P) (F)
Bowel problems (P) (F)	HIV/AIDS (P) (F)	Weight Gain/Loss (P) (F)
Cancer (P) (F)	Kidney Problems (P) (F)	High blood pressure (P) (F)
Depression (P) (F)	Osteoporosis (P) (F)	Substance Abuse (P) (F)
Diabetes (P) (F)	Ulcers (P) (F)	Other:_____

ALLERGIES: _____
DO YOU USE ALCOHOL? YES NO HOW MUCH? _____ HOW OFTEN? _____
DO YOU USE NON-PRESCRIBED DRUGS? YES NO WHAT? _____
DO YOU USE VITAMINS OR HERBAL REMEDIES? YES NO WHAT? _____
DO YOU SMOKE? YES NO _____ Packs/day for _____ years.
DO YOU HAVE ANY IMPLANTED DEVICES? YES NO IF YES, WHERE? _____
ARE YOU PREGNANT? YES NO UNSURE

Current Medications:	GOOD/BAD EFFECT	Current Medications:	GOOD/BAD EFFECT
1._____	_____	4._____	_____
2._____	_____	5._____	_____
3._____	_____	6._____	_____

Current employer: _____ Job: _____
Job Duties: _____
Number of years at this job: _____ Are you currently working?: No Yes
Last day worked: _____ Is there light duty available?: No Yes
How do you like your job? _____
Contact person or case manager: _____ Phone: _____
Do you have a lawyer involved with your injury? Whom? _____

FAMILY/PRIMARY CARE DOCTOR:
Name: _____
Address: _____
Phone: _____

WHOM SHOULD WE CALL IN CASE OF EMERGENCY?
Name: _____
Address: _____
Phone: _____

PLEASE RATE THE SEVERITY OF YOUR PAIN <u>RIGHT NOW</u>: Circle a number
(0=NO PAIN / 10=WORST PAIN IMAGINABLE) 0 1 2 3 4 5 6 7 8 9 10

PLEASE RATE THE SEVERITY OF YOUR PAIN <u>ON AVERAGE</u>: Circle a number
(0=NO PAIN / 10=WORST PAIN IMAGINABLE) 0 1 2 3 4 5 6 7 8 9 10

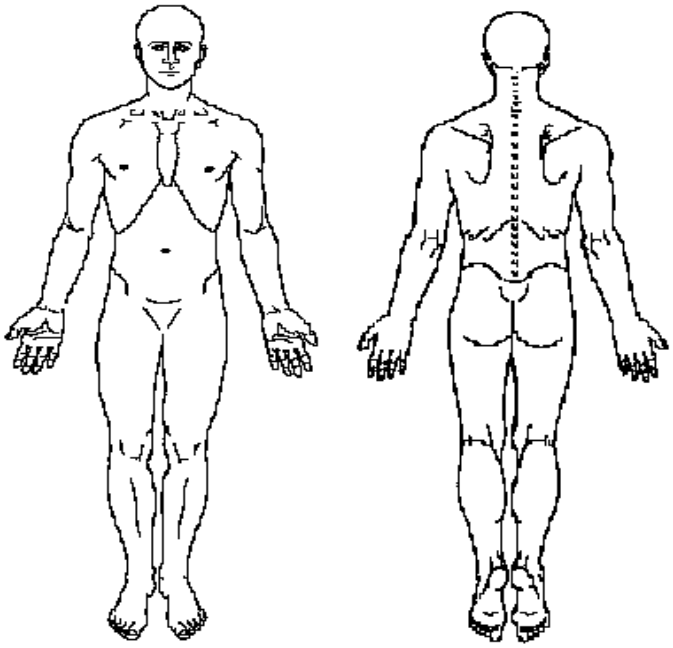
PLEASE RATE THE SEVERITY OF YOUR PAIN <u>AT BEST</u>: Circle a number
(0=NO PAIN / 10=WORST PAIN IMAGINABLE) 0 1 2 3 4 5 6 7 8 9 10

PLEASE RATE THE SEVERITY OF YOUR PAIN <u>AT WORST</u>: Circle a number
(0=NO PAIN / 10=WORST PAIN IMAGINABLE) 0 1 2 3 4 5 6 7 8 9 10

Please indicate where you have pain **<u>now</u>** and what type(s) of sensations you feel **<u>now</u>**.
Use the symbols below to describe your pain.

<u>DO NOT</u> indicate areas of pain, which are not related to your present injury or condition.

S = Stabbing
B = Burning
P = Pins and Needles
N = Numbness
A = Aching



Do you have any questions or comments? _____

_____

_____

Please describe how your pain/injury has impacted your personal, social and work life: _____

_____

_____

_____

_____

_____