

PATIENT NAME: _____

DATE: _____

What is your **Primary Complaint**? _____

Describe the **Location** of your **symptoms**: _____

How long has this problem bothered you? _____

How often does it bother you? Constantly Daily Weekly ___x /wk Monthly ___x / month

Does this problem **refer** to other areas? **Yes** **No** Where? _____

Has this problem been progressively getting **better** or **worse** over time?

What is the **level of your pain** at it's **worst**? No pain **0 1 2 3 4 5 6 7 8 9 10** Worst pain of my life

What is the **level of your pain** at it's **best**? No pain **0 1 2 3 4 5 6 7 8 9 10** Worst pain of my life

What is the **Character (Quality)** of your pain? Dull/ache Sharp/stabbing Burning Shooting
Pinching Numbness / tingling Variable Other _____

What **aggravates** your condition? _____

What **relieves** your condition? _____

What **other treatment** have you tried for this condition?

Rest Ice/Heat Stretches Physiotherapy Acupuncture Massage Other _____

What **activities** does this **prevent** you from doing? _____

Does this problem cause you to experience any **sleep problems**?

Difficulty falling asleep Waking during the night Waking earlier than normal Waking unrested

Please list any **other complaints** (health problems) you would **like to get rid of**:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Is there anything **preventing** you from getting your problem(s) taken care of? Yes No

Do you have any **Concerns**? None Time Transportation Cost Other _____

What are your **goals for care**? Pain/symptom relief Improved function Correction of the "Cause"
Maintenance & Prevention of other problems Overall Health & Wellness

HISTORY OF SPINAL TRAUMA:

Have you ever been involved in any **motor vehicle accidents** (minor or major)? Yes No

1. **Date**(year): _____ **Injuries/Treatment**: _____

2. **Date**(year): _____ **Injuries/Treatment**: _____

Have you ever had any **major falls**? Down the stairs On ice Off Bikes From trees
Other _____

Have you ever had any **Sports injuries**? Sprain / Strain Fracture Concussion Dislocation Other
Describe: _____

What type of **sleep posture** do you have? Belly Side Back More than 1 pillow Futon/Waterbed

What type of **Physical stress** do you have at home/work? Heavy lifting Repetitive strain
Overhead work Prolonged sitting/standing Computer/desk work Other _____