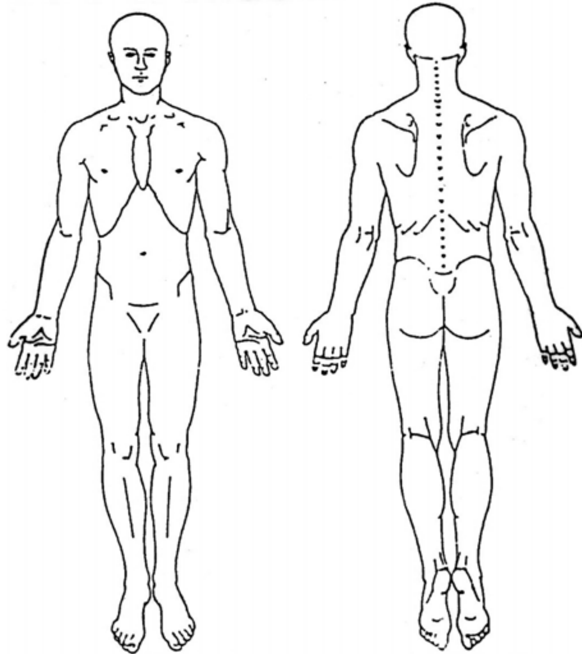
Patient Information

Patient Name: ________________________ Date: ___________________

1. Chief Complaints: ____
____
____

2. Please shade all areas of discomfort caused by your current injury, as well as any other existing pain or discomfort.



Is your pain: Constant Intermittent

What percent of the day felt? _____________

3. What increases your pain: ____
____
What decreases your pain: ____
____

4. Explain how and when your injury/symptoms occurred:______________________
____
____

5. Have you had anything similar to this before? Yes___ No___
If yes, when and how often:____
____

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Patient Information Page 2

Patient Name:___________________________ Date:____________________

6. Do you have difficulty sleeping at night due to pain? Yes___ No___
What is your sleeping posture and how many pillows do you sleep with:___________
____

7. Does coughing or sneezing increase your symptoms? Yes___ No____

8. Have you had any diagnostic tests for this current problem?
X-ray___ MRI___ Other______________________________________
What date were the tests performed and what were the results: __________________
____

9. List any present medications you are taking: ________________________________
____

10. Allergies to medication: Aspirin___ Cortisone___ Lidocaine___
Other:____

11. Miscellaneous medical: Are you pregnant? Yes No
Do you have a pacemaker? Yes No

12. Previous surgeries/dates: ____
____
____

13. Do you work? Yes___ No___
If yes, what type of work do you do: ____
What are the physical requirements of you job:________________________________
____

14. Check any treatments you have had for this current problem: Chiropractic______
Physical Therapy___, what type of treatment__________________________________
Epidural Injections___ Facet Injections___ Other:_________________________
____

15. Did this treatment help? Yes___ No___