



Date of Appointment: _____ SS: _____

Name: _____

Date of Birth: _____ Age: _____

Referring Physician: _____

Current Complaint: _____

Duration of Complaint: _____

Accident: Yes No Current Lawsuit: Yes No

Spinal Fracture: Yes No Accident Type: MVA Fall Date: _____

Pain: Intermittent Constant

Describe Pain: Sharp Burning Stabbing Tingling Achy

Other: _____

Pain Intensity On Scale Of 1(least)-10(most): _____

Is The Pain: Improving Getting Worse Remaining the Same

Do You Have Back Pain: Yes No

If Yes, Does the Pain Radiate to Your Lower Extremities (Buttocks, Legs, Thighs, or Feet): Yes No

Location of Your Worst Pain: Back Lower Extremities

Do You Have Neck Pain: Yes No

If Yes, Does the Pain Radiate to Your Lower Upper (Shoulders, Arms, or Hands): Yes No

Location of Your Worst Pain: Neck Upper Extremities

Date of Appointment: _____ SS: _____

Name: _____

Pain Worse With: Standing Sitting Lying down Working Walking
 Sleeping Stairs Leaning Forward
 Other: _____

Pain Better With: Standing Sitting Lying down Changing Position
 Working Walking Sleeping Stairs Leaning Forward
 Other: _____

Associated Symptoms: Intermittent Constant None

Dexterity Issues: Yes No Sensory Disturbance: Yes No
 Weakness: Yes No Balance Issues: Yes No
 Incontinence: Bowel Bladder None
 History of Cancer: Yes No
 Please Explain: _____

Recent Weight Loss: Yes No

If Yes, How Many LBS: _____ Height: _____ Weight: _____

Tobacco Use? Yes No - If Yes, Do You - Smoke Chew
 Alcohol Use? Yes No Recreational Drug Use? Yes No
 Occupation: _____ Receiving Disability? Yes No

Treatment	Past	Recent	# Of Sessions	Treatment	Past	Recent
Physical Therapy	<input type="radio"/>	<input type="radio"/>		Bracing/Collar	<input type="radio"/>	<input type="radio"/>
Chiropractic	<input type="radio"/>	<input type="radio"/>		Rest	<input type="radio"/>	<input type="radio"/>
Acupuncture	<input type="radio"/>	<input type="radio"/>		Narcotic Medications	<input type="radio"/>	<input type="radio"/>
Injections	<input type="radio"/>	<input type="radio"/>		NSAID Medications	<input type="radio"/>	<input type="radio"/>

Past Spinal Surgery: Yes No

If Yes, Please List Procedure & Date: _____
