New Patient/Re-activate

Name:________________________ DOB: __________ Today's Date: __________

History of Present Illness

What are your symptoms? List all that apply with the most severe listed first.

1. ____
2. ____
3. ____
4. ____
5. ____

How did the symptoms occur? _______________________________________

When did the symptoms begin? ________________

Have you missed any work or school? ______ How much? _____________

Have you been doing anything at home for the pain? _____ What? ______________

Did you have any similar pain or any other pain before this occurred? ______________

Where/what? ____

Have you seen anyone for this condition previously? ______ Who? ______________

Have there been any prior treatments? _____ What? (Circle all that apply) injections, physical therapy, prescription medications, over the counter medications, massage, acupuncture other ____

Did you notice relief with any of the above? ________________________________

Have you ever had this condition before? No _____ 1-3 times _____ 4+ ______

Do you have another health condition? (Circle all that apply) diabetes, high blood pressure, high cholesterol, asthma, IBS/Colitis, cancer, arthritis, infertility issue, other __________

Office use only: Height _____ Weight_____ Pulse_____ Respiratory_____ Blood Pressure ____/____

Chief Complaint: Answer the questions that apply to you.

Headaches:

Where do you feel your headaches? ____

What's the quality of your headache pain? (i.e. dull, throbbing) ___________________________

What symptoms do you experience with your headaches? Circle all that apply: nausea, vomiting, visual disturbance, altered hearing, ringing in ears, loss of balance, other _________

On a pain scale of 1-10, with 10 being the worst pain possible, how would you rate your headache pain? ______/10

How often do you have headaches? _________________

Do you get pain/pressure behind your eyes? __________

Is it difficult to move your head with your headaches? _________

Do you have a feeling of a ripping/tear with your headaches? ______

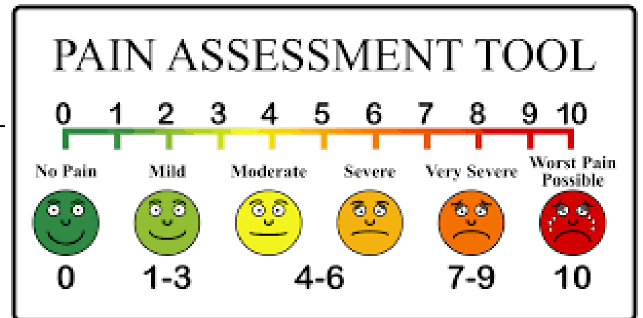
Is there a family history of headaches? _______

Do you have abnormal blood pressure? _______

Do you get pain in your jaw? _______

Do you have cracking in your jaw? _______

When was your last eye exam? _________



Neck:

On a pain scale of 1-10, with 10 being the worst pain possible, how would you rate your neck pain? ______/10

Does your neck pain radiate? If so, where? ____

How many pillows do you sleep with? __________

Mid Back:

On a pain scale of 1-10, with 10 being the worst pain possible, how would you rate your mid back pain? ______/10

Does your mid back pain radiate? If so, where? ____

Low back:

On a pain scale of 1-10, with 10 being the worst pain possible, how would you rate your low back pain? ______/10

Does your low back pain radiate? If so, where? ____

Do you have any impairment of bowel/bladder? ________

Do you wear heel lifts? _______

Do you wear foot orthotics? _______

Other (list): _____________

On a pain scale of 1-10, with 10 being the worst pain possible, how would you rate your pain? ______/10

Does your pain radiate? If so, where? ____

Activities of Daily Living (ADLs)

Please rate any ADLs that apply to you out of 10, with 10 being the worst pain possible and mark whether it is limited, painful, or difficult. If the activity is normal leave blank. Try to fill out at least three if possible.

L – Limited *P – Painful* *D – Difficult*

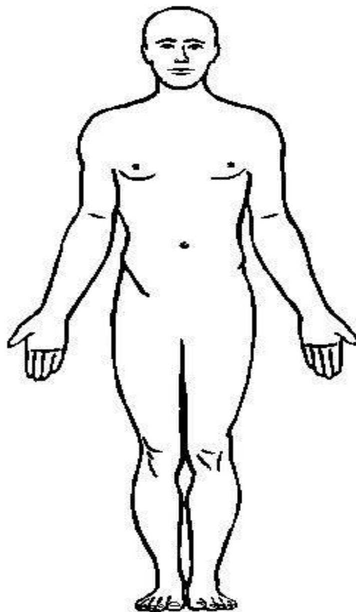
Example: **P** Sitting to Standing **3 /**10

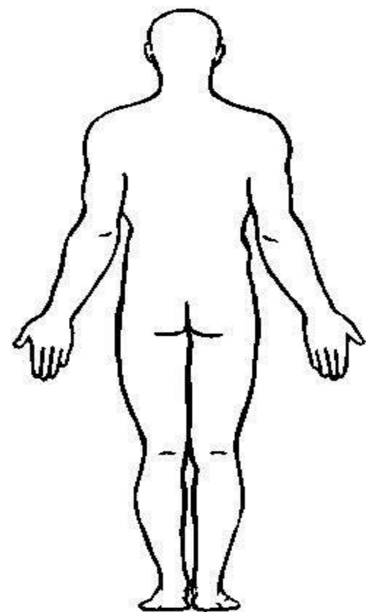
__ Sitting to Standing __/10	__ Dressing Self __/10	__Standing __/10	__Twist/Turn Right __/10
__Lying on Back __/10	__ Stooping __/10	__Walking __/10	__Sitting __/10
__Lying on Sides __/10	__ Pushing __/10	__Kneeling __/10	__ Driving __/10
__Lying on Stomach __/10	__Pulling __/10	__Bending __/10	__Riding __/10
__Turn over in bed __/10	__ Reaching __/10	__In/Out of Car __/10	__Using Computer __/10
__Cough/Sneeze/Grunt __/10	__Lifting __/10	__Sexual Activity __/10	__Using Stairs __/10
__Sleeping__/10	__Gripping __/10	__Twist/Turn Left __/10	

Is it difficult getting to sleep? __ How many times do you wake up at night? __

Using the provided key, mark the figure where you are experiencing your pain.

XXX	Burning Pain
(((	Aching Pain
000	Pins & Needles
----	Numbness
:::	Sharp Pain





Is your pain constant or does it come and go? _____________

Is your pain getting better, worse, or staying the same? _______________

In the table below, list your areas of complaint and indicate what time of day your condition is better or worse.

Area of Complaint	Time of Day	Better or Worse
	AM	
	Mid-Day	
	PM	
	AM	
	Mid-Day	
	PM	
	AM	
	Mid-Day	
	PM	

What makes the condition BETTER?

Head/Neck: ____________________________________

Mid Back: ______________________________________

Low Back: ______________________________________

Shoulder, Arm, Wrist, Hand:________________________

Hip, Ankle, Leg, Foot:______________________________

Other: ____

What makes the condition WORSE?

Head/Neck: _______________________________

Mid Back: _________________________________

Low Back:__________________________________

Shoulder, Arm, Wrist, Hand: ___________________

Hip, Ankle, Leg, Foot:________________________

Other: ____________________________________

PFSH

Past Medical History

Have you had any x-rays taken of the area? ____When?_____________________

Females: Are you pregnant? ___ No ___ Yes – Due Date: ____________ Dr: ________________

Date of last gynecological & breast exam: ___________________

Males: Date of last prostate & testicular exam: ______________________

Describe any major illnesses, injuries, falls, hospitalizations, accidents, or surgeries:

Date: Condition:

__________ ____

__________ ____

Social History

Student? ___ Part Time ___ Full Time ___ N/A

Occupation:____ Years with employer? ____Hours/week? ______

Recreational/Hobbies: _______________________Do you exercise? _____ How Often? ________ In what way? _________

Do you consume caffeine? _____ How much? ________________ How often? ______________

Do you consume alcohol? ______ How much? ________________ How often? _____________

Smoking Status:

___ Smoker – Daily (___ packs/day or ___cigarettes/day – for ____ years)

___ Smoker –Some days (NOT daily) ___ Former ___ packs/day or ___cigarettes/day – from age: ___ to age ___

___Never

Family Health History

List any current or past health conditions of your family members (if deceased, indicate at what age and from what)

Father: ____

Mother: ____

Sisters: ____How Many? _____

Brothers:____How Many? _____

Children:____How Many?_____

Allergies

- ☐ None
- ☐ See List

Drug/Medication	Food	Other
_______________________	_______________________	_______________________
_______________________	_______________________	_______________________
_______________________	_______________________	_______________________

Current Prescription Medications

- ☐ None
- ☐ See List

Name of Prescription	Dose (mg, mL)	Form	Duration
____________________	_____________	________	___x per______
____________________	_____________	________	___x per______
____________________	_____________	________	___x per______
____________________	_____________	________	___x per______
____________________	_____________	________	___x per______
____________________	_____________	________	___x per______

System Review Questions

Have you had any problems with the following areas now or in the past? (Y = Yes and N = No) (Circle the conditions that apply)

___ Eyes (glasses, contacts, pink eye, glaucoma, macular degeneration, cataracts)

___Ears, Mouth, Nose, Throat (ear infection, hearing loss, sinus infections, nasal polyps)

___Cardiovascular (heart murmur, irregular heartbeat, hypertension, heart disease, high cholesterol)

___Respiratory (lung disease, difficulty breathing, asthma, bronchitis, COPD, emphysema, pneumonia)

___Neurological (weakness, numbness)

___ Endocrine (thyroid, hormonal imbalance, liver disease, kidney disease, diabetes)

___Gastro-Intestinal (acid reflux, colic, constipation, I.B.S, crohns disease, stomach ulcers, intestinal ulcers)

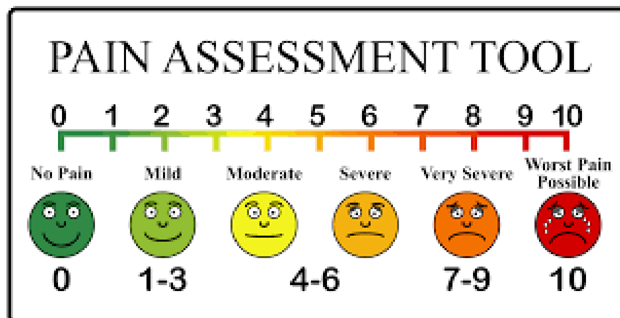
___Genito-Urinary (bed wetting, kidney stones, UTI)

___Musculoskeletal (fractures, dislocations, spondylolisthesis, sprain/strain, arthritis)

___Skin (rashes, dryness, psoriasis, hair loss, eczema)

___Psychiatric (anxiety, depression, bipolar, ADD/ADHD)

___Illness (fever, chills, nausea, chest pain, dizziness, headache)



Neck and Back Bournemouth Questionnaire

0 – No pain, 10 – Worst Possible Pain

Please circle your answer.

1. *Over the past week, on average, how would you rate your pain?*

   Neck: 0 1 2 3 4 5 6 7 8 9 10

   Back: 0 1 2 3 4 5 6 7 8 9 10

2. *Over the past week, how much has your pain interfered with your daily activities?*

   Neck: 0 1 2 3 4 5 6 7 8 9 10

   Back: 0 1 2 3 4 5 6 7 8 9 10

3. *Over the past week, how much has your pain interfered with your ability to take part in recreational, social and family activities?*

   Neck: 0 1 2 3 4 5 6 7 8 9 10

   Back: 0 1 2 3 4 5 6 7 8 9 10

4. *Over the past week, how anxious have you been feeling?*

   Neck: 0 1 2 3 4 5 6 7 8 9 10

   Back: 0 1 2 3 4 5 6 7 8 9 10

5. *Over the past week, how depressed have you been feeling?*

   Neck: 0 1 2 3 4 5 6 7 8 9 10

   Back: 0 1 2 3 4 5 6 7 8 9 10

6. *Over the past week, how have you felt your work has affected your pain?*

   Neck: 0 1 2 3 4 5 6 7 8 9 10

   Back: 0 1 2 3 4 5 6 7 8 9 10

7. *Over the past week, how much have you been able to control your pain on your own?*

   Neck: 0 1 2 3 4 5 6 7 8 9 10

   Back: 0 1 2 3 4 5 6 7 8 9 10

Quadruple Visual Analog Scale

0 – No Pain, 10 – Worst Possible Pain

Please provide your answer in the correct box.

Area	Best	Worst	Usual	Now
Neck				
Mid Back				
Low Back				

Headache Disability Index – Fill out ONLY if headaches are one of your main complaints

Circle the correct response:

I have a headache: 1 per month More than 1 but less than 4 per month More than 1 per week

My headache is: Mild Moderate Severe

Mark an 'x' in the appropriate box

	Yes	Sometimes	No
Because of my headaches, I feel handicapped.			
Because of my headaches, I feel restricted in performing my routine daily activities.			
No one understands the effect my headaches have on my life.			
I restrict my recreational activities because of my headaches.			
My headaches make me angry.			
Sometimes I feel that I am going to lose control because of my headaches.			
Because of my headaches, I am less likely to socialize.			
My spouse, or family and friends have no idea what I am going through because of my headaches.			
My headaches are so bad that I feel I am going insane.			
My outlook of the world is affected by my headaches.			
I am afraid to go outside when I feel that a headache is starting.			
I feel depressed because of my headaches.			
I am concerned that I am paying penalties at work and home because of my headaches.			
My headaches place stress on my relationships with family and friends.			
I avoid being around people when I have a headache.			
I believe my headaches are making it difficult for me to achieve my goals in life.			

I am unable to think clearly because of my headaches.			
I get tense because of my headaches.			
I do not enjoy social gatherings because of my headaches.			
I feel irritable because of my headaches.			
I avoid traveling because of my headaches.			
My headaches make me feel confused.			
My headaches make me feel frustrated.			
I find it difficult to read because of my headaches.			
I find it difficult to focus my attention away from my headaches and on other things.			