**Check all problems that apply to you today:**

☐ Neck pain ☐ Right arm pain ☐ Left arm pain

☐ Back pain ☐ Right leg pain ☐ Left leg pain

☐ Difficulty walking ☐ Numbness

Other: ______________________________

**Mark these drawings according to where you hurt. Please indicate sensations you feel by referring to the key below.**

**KEY**

| | |
|---|---|
| /////// | Stabbing |
| XXXXX | Burning |
| 00000 | Numbness |
| ===== | Pins & Needles |
| ++++++ | Aching |

**PAIN LEVEL**

**0** No pain

**1** Mild pain; you are aware of it but it doesn't bother you

**2** Moderate pain that you can tolerate without medicine

**3** Moderate pain that requires medication to tolerate

**4-5** More severe pain; you begin to feel antisocial

**6** Severe pain

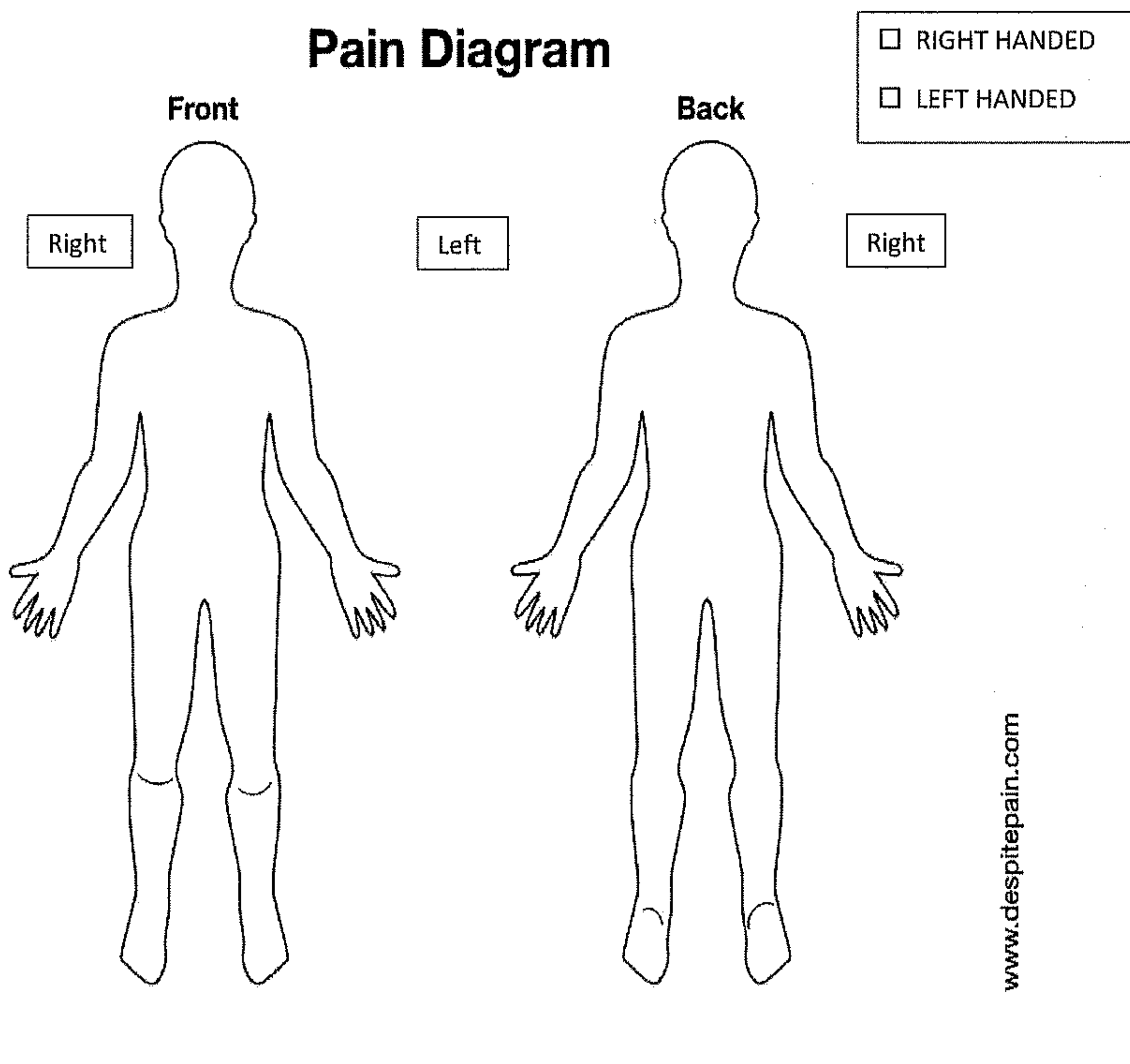
**7-9** Intensely severe pain

**10** Most severe pain; it may make you contemplate suicide

## Pain Diagram

☐ RIGHT HANDED

☐ LEFT HANDED




**CIRCLE YOUR CURRENT PAIN LEVEL**

0 1 2 3 4 5 6 7 8 9 10

**WHAT IS YOUR PAIN LEVEL AT ITS WORST? (0-10)** __________

Name: ______________________ Date of Birth: __________ Date : __________

What makes your pain better? ______________________________

What makes your pain worse? ______________________________

**Have you had?**

**Physical Therapy** ☐ yes ☐ no if YES, name of facility ______________________________

**Chiropractic Care** ☐ yes ☐ no if YES, name of facility ______________________________

**Diabetic Foot Exam** ☐ yes ☐ no if YES, name of facility ______________ Date: ________ A1C: ____

**MEDICATION LIST** *****PLEASE PROVIDE LIST TO THE STAFF*****

| Name | Dose | Frequency | Prescribing Doctor |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

**ALLERGIES** ☐ **No Known DRUG Allergies** ☐ **No Known Non Drug Allergies**

**Medication(s)** ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ NSAIDS ☐ IVP Dye

**Other Medications** ______________________________

**Other** ☐ Tape ☐ Latex ☐ Seasonal **Food** ☐ Shellfish ☐ Gluten

**Any other:** ______________________________

**HABITS** **Smoking Status** ☐ Never smoked ☐ Everyday smoker ☐ Some day smoker ☐ Former smoker

**If smoker please circle:** Cigarette / Cigar / E-Cigarette or Vape #_____pack(s) cigarette(s) per day

**Smokeless Tobacco Status** ☐ Never ☐ Everyday ☐ Former **Please circle:** Snuff / Tobacco

**ALCOHOL CONSUMPTION** ☐ Non-drinker # of drinks per day_____ # of drinks per week_____

☐ Former drinker

| SURGICAL HISTORY | | | DATE |
|---|---|---|---|
| Knee Replacement | ☐ Left | ☐ Right | |
| Knee Arthroscope | ☐ Left | ☐ Right | |
| Hip Replacement | ☐ Left | ☐ Right | |
| Hysterectomy | | | |
| Tubal Ligation | | | |
| C-Section | | | |
| Tonsillectomy | | | |
| Bone Fracture Repair | | | |
| Prostate Resection (TURP) | | | |

Name: ______________________ Date of Birth: ______________ Date: __________

| SURGICAL HISTORY continued | DATE |
|---|---|
| Thyroid Removal | |
| Appendectomy (appendix) | |
| Cholecystectomy (gallbladder) | |
| Coronary Artery Bypass Grafting (GABG)/heart bypass | |
| Posterior Cervical Fusion (neck surgery through the back) | |
| Discectomy Cervical (surgery for disc herniation in neck, through the front) | |
| Fusion Lumbar (low back fusion) | |
| Discectomy Lumbar (surgery for disc herniation low back) | |
| Rotator Cuff Repair | |
| **List other surgeries:** | |
| | |

**MEDICAL HISTORY** **Check all problems that apply to you NOW or in the PAST.**

| **Heart Conditions** | **Yes** | **No** | **Neurological Conditions** | **Yes** | **No** |
|---|---|---|---|---|---|
| Coronary Artery Disease | | | Depression | | |
| Irregular Heartbeat | | | Anxiety | | |
| Valve problem/replacement | | | Bipolar Disorder | | |
| Heart Attack | | | Panic Attacks | | |
| Angina | | | Stroke/CVA | | |
| High Blood Pressure | | | Headache | | |
| **Lung/Breathing Conditions** | **Yes** | **No** | Drug Dependence | | |
| Asthma | | | Alcohol Dependence | | |
| Bronchitis | | | Seizure Disorder/Epilepsy | | |
| COPD | | | **Endocrine Conditions** | **Yes** | **No** |
| Lung Cancer | | | Diabetes | | |
| **Eyes/Ears/Nose/Throat** | **Yes** | **No** | Thyroid Disease | | |
| Glaucoma | | | Breast Cancer | | |
| Cataracts | | | Last Menstrual Period (if applicable) | | |
| Sinusitis | | | **GI/Digestive System** | **Yes** | **No** |
| Laryngitis | | | Ulcer Disease | | |
| TMJ Syndrome | | | Crohn's Disease | | |
| Hearing Loss | | | Irritable Bowel Syndrome (IBS) | | |
| **Genito-Urinary System** | **Yes** | **No** | Ulcerative Colitis | | |
| Kidney Stone | | | GI Bleeding | | |
| Prostate Cancer | | | Hepatitis | | |
| BHP-Benign Prostatic Hypertrophy | | | Cirrhosis | | |
| Chronic Kidney Disease: | | | GERD | | |
| Stage: I II III IV V | | | Hemorrhoids | | |
| | | | Colon Cancer | | |

**Other Medical Problems:** ______________________________

Name: ______________________ Date of Birth: ______________ Date: __________

**SOCIAL HISTORY** *Check all situations that apply to you.*

**Employment**

☐ Full time ☐ Part time ☐ Disabled

☐ Retired

☐ Unemployed ☐ Laid off

☐ Unable to work due to pain

**Student**

☐ Full Time ☐ Part time

☐ Unable to attend school due to pain

**Special Living Arraignments**

☐ Assisted Living Facility

☐ Living Temporarily

(at shelter or mission, with friends, or half way house)

☐ Skilled Nursing Facility

**Martial/Child Status**

☐ Married ☐ Single

☐ With children ☐ No children

☐ Pregnant- # of months: __________

**FAMILY HISTORY** *List any medical history which applies to your **immediate family**.*

______________________________________________________________________________

______________________________________________________________________________

***Have you had any of the following symptoms over the past three months?***

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Weight loss more than 10 lbs. | | | Diarrhea | | |
| Weight gain more than 10 lbs. | | | Constipation | | |
| Fevers or chills | | | Loss of bowel control/incontinence) | | |
| Night sweats | | | Blurry vision | | |
| Loss of appetite | | | Double vision | | |
| Skin rashes | | | Loss of vision | | |
| Easy bruising | | | Burning on urination | | |
| Sore throat | | | Bleeding on urination | | |
| Hearing loss | | | Loss of bladder control/incontinence) | | |
| Ringing in ears | | | Missed most recent menstrual period | | |
| Shortness of breath at rest | | | Loss of memory/confusion | | |
| Shortness of breath with exercise | | | Weakness | | |
| Coughing | | | Seizures or convulsions | | |
| Chest pain | | | Dizziness or lightheaded | | |
| Heart racing, palpitations | | | Passing out episodes | | |
| Swelling of the ankles | | | Feelings of depression or sadness | | |
| Stomach pain | | | Stress increases pain | | |
| Nausea | | | Difficulty sleeping | | |
| Vomiting | | | Increased irritability | | |

*Revised September 2019*

Name: ______________________________ Date of Birth: ________________ Date: __________