LAST NAME: _____ FIRST NAME: _____AGE: _____ HEIGHT: _____ WEIGHT: _____

**PLEASE MARK IF YOU HAVE:**

| | | |
|---|---|---|
| ____ ANEMIA | ____ PACEMAKER | ____ ALLERGIES |
| ____ BACK PAIN | ____ ANGINA | ____ ASTHMA |
| ____ BRONCHITIS | ____ BLOOD CLOT/ EMOBLI | ____ BOWEL/BLADDER PROBLEMS |
| ____ DRINK ALCOHOL | ____ CORONARY HEART DISEASE | ____ DIZZINESS OR FAINTNESS |
| ____ GOUT | ____ EMPHYSEMA | ____ EPILEPSY/SEIZURES |
| ____ HERNIA | ____ HEARING DIFFICULTIES | ____ HEART ATTACK |
| ____ PARKINSON'S | ____ HIGH BLOOD PRESSURE | ____ KIDNEY DISEASE |
| ____ SEVERE/FREQUENT HEADACHE | ____ PNEUMONIA | ____ VISION DIFFICULTIES |
| ____ STROKE / TA | ____ SLEEPING PROBLEMS | ____ VARICOSE VEINS |
| ____ THYROID PROBLEM | ____ WOMEN'S HEALTH ISSUES | ____ WEAKNESS |
| ____ WEIGHT LOSS/ ENERGY LOSS | ____ PINS OR METAL IMPLANTS | |
| ____ COMPLEX REGIONAL PAIN SYNDROME | ____ CANCER | ____ DIABETES TYPE 1 / TYPE 2 |
| ____ INFECTIOUS DISEASE | ____ PELVIC FLOOR | ____ OTHER SURGERY |
| ____ VERTIGO / BALANCE | | |
| ____ I HAVE HAD PT TREATMENTS AT HOME | | |
| ____ I LIVE ALONE | ____ I AM A CARETAKER FOR SOMEONE ELSE | ____ MY HOME HAS STAIRS |
| ____ I USE A CANE | ____ I USE A WHEELCHAIR | ____ I USE A WALKER |

____ LIST JOINT REPLACEMENT(S) _____

____ LOCATION OF ARTHRITIS: _____

____ LOCATION OF NUMBNESS/TINGLING/NEUROPATHY: _____

**HOW OFTEN DO YOU EXERCISE**: ____ NEVER ____ 1X PER WEEK ____ 2X PER WEEK ____ 3X PER WEEK ____ 4X PER WEEK

**DOES YOUR ROUTINE, OR WORK, AGGRAVATE YOUR INJURY**? ___ NO ___ ONCE WEEKLY ____ TWICE WEEKLY ____ DAILY

___ UNABLE TO PARTICIPATE IN YOUR NORMAL ROUTINE

**DO YOU USE TOBACCO?** NO SMOKE CHEW SNUFF **HAVE YOU RECEIVED TOBACCO CESSATION COUNSELING?** YES NO

**ARE YOU PREGNANT?** YES NO

**ARE YOU ALLERGIC TO ANY MEDICATIONS, METALS, LATEX?** YES / NO **IF YES, PLEASE LIST MEDICATIONS**

_____

**PLEASE LIST ANY MAJOR SURGERIES AND HOSPITALIZATIONS** _____ DATE: _____

_____ DATE: _____ _____ DATE: _____

**PLEASE MARK THE FOLLOWING IF ANY OF THESE DIAGNOSTIC TESTS HAVE BEEN PERFORMED?**

____ X-RAYS DATE:_____ RESULTS:_____

____ MRI DATE:_____ RESULTS:_____

____ CAT SCAN DATE:_____ RESULTS:_____

____ EMG/NCV DATE:_____ RESULTS:_____

**HAVE YOU BEEN TREATED BY A PHYSICAL THERAPIST?** YES/ NO **CHIROPRACTOR?** YES/ NO **MASSAGE THERAPIST?** YES/ NO

IF YES, APPROXIMATE DATE:_____

WHAT WERE YOU TREATED FOR?_____

**DATE OF ONSET OF PAIN?** _____ **WAS IT DUE TO AN INJURY?** YES/ NO

**IS THIS PROBLEM WORK RELATED?** YES/ NO **MOTOR VEHICLE ACCIDENT?** YES/ NO

**PLEASE DESCRIBE YOUR PROBLEM:**

_____

_____

_____

**PLEASE CHECK THE FOLLOWING WHICH BEST DESCRIBE YOUR PAIN**

____ ACHING ____BURNING ____CONSTANT ____CRAMPING ____DEEP ____DULL ____HEAVY

____NUMB ____STABBING ____THROBBING ____VARIABLE ____WEAK ____PINS & NEEDLES

**RATE YOUR PAIN WHEN THE INJURY FIRST OCCURRED**: 0 (no pain)- 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (worst pain imaginable) _____

**RATE YOUR CURRENT/RECENT PAIN AT WORST** from 0-10 _____ **RATE YOUR PAIN AT ITS BEST** from 0-10 _____

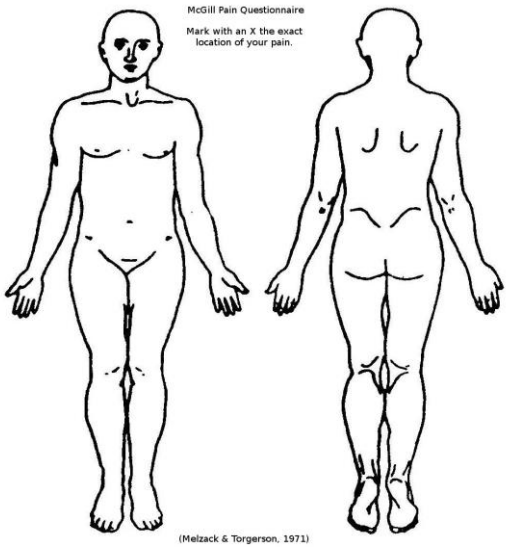
**PAIN IS AGGRAVATED BY**: ____REACHING BACK ____LYING FLAT ____GETTING OUT OF BED ____DRESSING & GROOMING

____CARRYING ITEMS ____CLIMBING STAIRS _____ COOKING ____LIFTING ANYTHING ____LIFTING HEAVY WEIGHTS

____TWISTING ____WALKING ____LOOKING UP & DOWN ____RAISING ARMS OVER THE HEAD

**PAIN IS EASED BY**: ___ICE ___HEAT ___PAIN MEDICATION ___ LYING FLAT ___STRETCHING ___EXERCISE ____REST ___NOTHING

PLEASE INDICATE THE AREA OF PAIN




**I, THE UNDERSIGNED, STATE THAT I HAVE ANSWERED**

**THIS QUESTIONAIRE TO THE BEST OF MY KNOWLEDGE.**

_____

**SIGNATURE (parent/guardian if under 18)**

_____

**DATE**