INITIAL VISIT INFORMATION

DATE ___/___/___

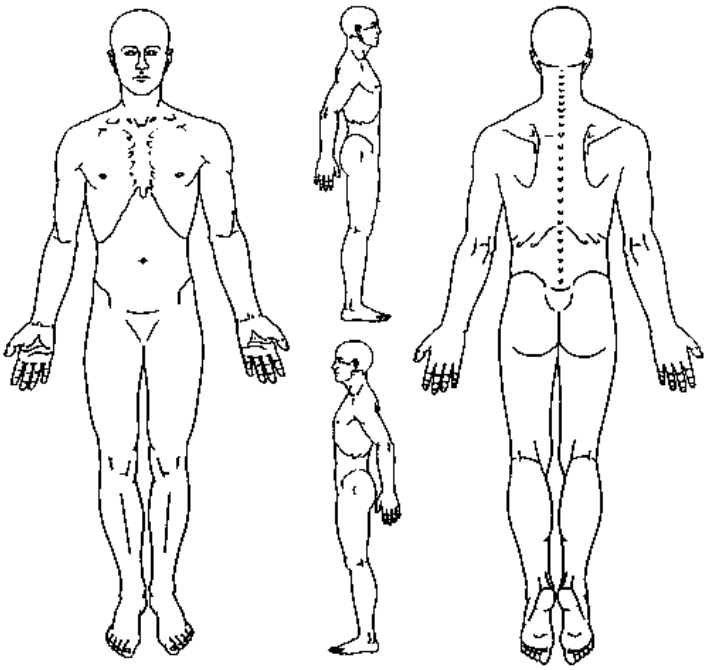
Your Name: _____

Referred By: _____

Age: _____ **YRS** **Sex (Circle) :** ☐ **M** ☐ **F**

WHERE is your pain located? Using these pictures, shade with a pen or pencil the parts of your body that are affected by pain.

Right ↘ ↓ Right ↓ ↙ Right



↑ LEFT ↑ LEFT ↑ LEFT ↑

When / How long ago did your pain start?

_____ Years _____ Month(s)

_____ Week(s) _____ Day(s)

Any Specific Date? _____ /_____ / _____

How did your pain start?

- ☐ Traffic Accident
- ☐ Unknown
- ☐ Work Injury

How often do you have your pain? (Please check one)

- ☐ Constantly (80-100% of time)
- ☐ Frequently (50-80% of the time)
- ☐ Intermittently (25-50% of the time)
- ☐ Occasionally (less than 25% of the time)

How would you grade AVERAGE DAILY intensity of your pain? (PLEASE CIRCLE)
(Zero = "no pain", 10 = "worst pain imaginable")

0	1	2	3	4	5	6	7	8	9	10

How do the following affect your pain?
(Please check the ones applicable to your condition)

	Increases Pain	Reduces Pain
Standing	☐	☐
Sitting	☐	☐
Lying Down	☐	☐
Walking	☐	☐
Exercise	☐	☐
Coughing or Sneezing	☐	☐
Passing Urine/ Bowels	☐	☐

Check additional symptoms you are experiencing with their location

- ☐ Tingling (pins-needles): _____
- ☐ Numbness: _____
- ☐ Cold / Hot skin: _____
- ☐ Cramps: _____
- ☐ Imbalance / Repeated Falls
- ☐ Weakness: _____
- ☐ Pain EVEN with bed-rest
- ☐ Chills / Night Sweats / Fever
- ☐ Uncontrolled loss of urine or bowels
- ☐ Weight loss (10-15 pounds in 2 weeks or less)

Check the treatments you have tried for your pain and complete the appropriate column on the right

- ☐ Physical Therapy for _____ Week(s)
- ☐ Name of Physical Therapy Center

  _____
- ☐ Chiropractor (name) _____
- ☐ Currently seeing your chiropractor ☐ YES ☐ NO
- ☐ Heat / Ice / Traction / TENS / Acupuncture (circle)
- ☐ Medications you have tried for the current pain:

  _____
- ☐ Injections (if any) done for the current pain:

  _____
- ☐ Surgery/surgeries done to address current pain:

  _____

  _____

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Please review the list of symptoms below. Please check the box ❑ next to the ones you suffer from:

- ❑ Weight gain
- ❑ Headache
- ❑ Seizures
- ❑ Fainting
- ❑ Memory loss
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Cough
- ❑ Tremors
- ❑ Anxiety
- ❑ Depression
- ❑ Hallucinations
- ❑ Suicidal thoughts
- ❑ Suicide attempts
- ❑ Poor appetite
- ❑ Constipation
- ❑ Chest pain
- ❑ Palpitations
- ❑ Swelling in legs
- ❑ Passing stones in urine
- ❑ Erectile dysfunction
- ❑ Abnormal vaginal bleed
- ❑ Painful muscles
- ❑ Painful /swollen joints
- ❑ Difficulty in hearing
- ❑ Easy bruising / bleeding
- ❑ Loud snoring
- ❑ Daytime tiredness

LIST YOUR MEDICAL HISTORY:

- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Hypothyroidism
- ❑ Heart Disease
- ❑ GERD
- ❑ Diabetes
- ❑ Anxiety
- ❑ Depression
- ❑ Asthma
- ❑ COPD / Emphysema
- ❑ Sleep Apnea
- ❑ Kidney Disease

Use following space to list any other medical conditions:

DOCUMENT ANY SURGICAL PROCEDURES THAT YOU EVER HAD (if possible, provide year):

- ❑ Tonsillectomy
- ❑ Appendectomy
- ❑ Breast Surgery
- ❑ Gall bladder removal
- ❑ Thyroid Removal
- ❑ Hysterectomy

Use following space to list other surgeries you had:

ALLERGIES: ❑ I HAVE NO ALLERGIES

- ❑ Penicillin
- ❑ CT Dye
- ❑ Sulfa
- ❑ Iodine
- ❑ MRI Dye
- ❑ Shellfish

LIST ALL MEDICATIONS YOU ARE TAKING

Include "over the counter" drugs and herbal supplements.

ARE ANY OF YOUR FAMILY MEMBERS SUFFERING FROM THE FOLLOWING?

Select all that apply:	Relationship to you:
❑ Cancer	
❑ Diabetes	
❑ Kidney Disease	
❑ Chronic Pain	
❑ Alcohol Abuse	
❑ Illegal Drug Abuse	
❑ Prescription Drug Abuse	

PERSONAL HISTORY

Are you currently working? YES ☐ NO ☐

What is your occupation? _____

Are you on disability? YES ☐ NO ☐

Reason for your disability? _____

Do you have any pending litigation related to your current pain issue? YES ☐ NO ☐

Do you live alone? YES ☐ NO ☐

Do you use tobacco? YES ☐ NO ☐

Number of cigarettes use per day: _____

How long have you been smoking? _____

Do you use alcohol? YES ☐ NO ☐

How often do you use alcohol: _____

Have you ever been treated for alcohol related problems? YES ☐ NO ☐

Have you ever used any street drugs? YES ☐ NO ☐

Have you ever been dependent on or treated for prescription drug abuse? YES ☐ NO ☐

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