Name: SSN: Date:

Leisure activities, including exercise routines:

Occupation, including activities that comprise your workday:

Age: Height: Weight:

Are you on a work restriction from your doctor? Yes No

Are you sensitive to latex? Yes No

Do you smoke? Yes No

Do you have a pacemaker? Yes No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

ALLERGIES: List any medication(s) you are allergic to:

Have you RECENTLY noted any of the following (check all that apply)?

- fatigue
- fever/chills/sweats
- nausea/vomiting
- weight loss/gain
- difficulty maintaining balance while walking
- falls
- numbness or tingling
- muscle weakness
- dizziness/lightheadedness
- heartburn/indigestion
- difficulty swallowing
- changes in bowel or bladder function
- constipation
- Diarrhea
- shortness of breath
- fainting
- cough
- headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- cancer
- heart problems
- chest pain/angina
- high blood pressure
- circulation problems
- blood clots
- stroke
- anemia
- bone or joint infection
- chemical dependency (i.e., alcoholism)
- depression
- lung problems
- tuberculosis
- asthma
- rheumatoid arthritis
- other arthritic condition
- bladder/urinary tract infection
- kidney problem/infection
- sexually transmitted disease/HIV
- pelvic inflammatory disease
- thyroid problems
- diabetes
- osteoporosis
- multiple sclerosis
- epilepsy
- eye problem/infection
- ulcers
- liver problems
- hepatitis
- pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- cancer
- diabetes
- tuberculosis
- heart problems
- stroke
- thyroid problems
- high blood pressure
- depression
- blood clots

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. 2. 3.
4. 5. 6.

Have you ever taken steroid medications for any medical conditions? YES NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

What date did your present symptoms start (roughly):

What do you think caused your symptoms?

My symptoms are currently: Getting Better Getting Worse Staying about the same

I should not do physical activities that might make my pain worse: Disagree Unsure Agree

Treatment received so far for this problem (chiropractic, injections, etc):

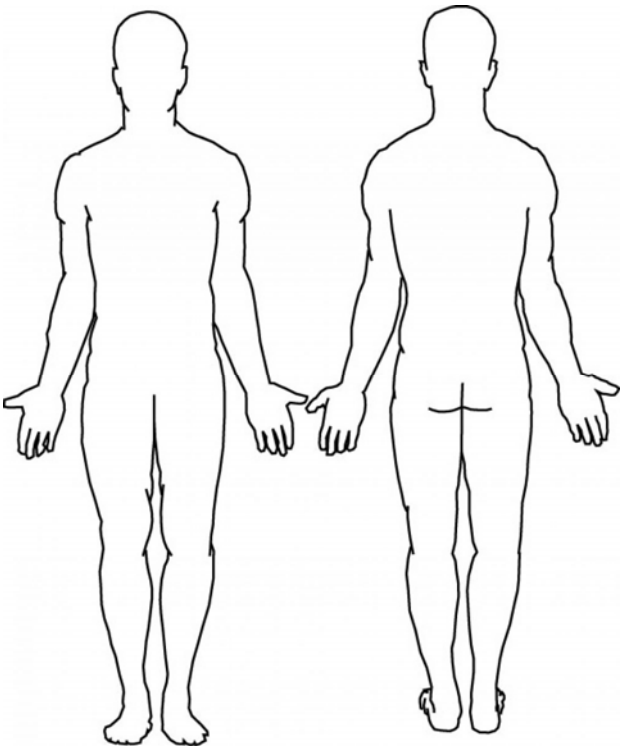
Please list special tests performed for this problem (x-ray, MRI, labs, etc):

Have you ever had this problem before: Yes No When: Treatment received:

How long did it take for you to feel better?

Body Chart:

Please mark the areas where you feel symptoms on the chart below with following numbers to describe your symptoms:



1. Shooting/sharp pain
2. Dull/aching pain
3. Numbness
4. Tingling

My symptoms currently: ○ Come and go ○ Are Constant ○ Are constant, but change with activity

Aggravating Factors: Identity up to 3 important positions or activities that make your symptoms worse:

1.

2.

3.

Easing Factors: Identity up to 3 important positions or activities that make your symptoms better:

1.

2.

3.

How are you currently able to sleep at night due to your symptoms?

○ No problem sleeping ○ Difficulty falling asleep ○ Awakened by pain ○ Sleep only with medication

When are your symptoms worst? ○ Morning ○ Afternoon ○ Evening ○ Night ○ After Exercise

When are your symptoms the best? ○ Morning ○ Afternoon ○ Evening ○ Night ○ After Exercise

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:

The best your pain has been during the past 24 hours:

The worst your pain has been during the past 24 hours: