PATIENT HISTORY FORM

Name: _____ Date: _____

Occupation: _____ Age: _____

1. When (roughly what date) did your present pain start?
   _____

2. How did it start? (Check appropriate box)
   - ☐ Lifting
   - ☐ Pulling
   - ☐ Twisting
   - ☐ Hit in the back
   - ☐ Fall
   - ☐ Auto accident
   - ☐ Bending
   - ☐ No accident

3. Your pain is worse in your: (Check appropriate boxes)
   - ☐ Back
   - ☐ Back and hip(s)
   - ☐ Neck
   - ☐ Down the leg(s)
   - ☐ Head
   - ☐ All of these
   - ☐ Arm(s)
   - ☐ None of these

4. How long have you been unable to work or do normal housework? _____

5. How long have you had any problem with your back, neck, legs, or arms? (Circle appropriate parts) _____

6. Your pain is: (Check appropriate boxes)

Better	Worse	No different	
☐	☐	☐	When coughing or sneezing
☐	☐	☐	Sitting in a straight chair
☐	☐	☐	Sitting in a soft easy chair
☐	☐	☐	Bending forward to brush your teeth
☐	☐	☐	When you wake up in the morning
☐	☐	☐	In the middle of the night
☐	☐	☐	Midday
☐	☐	☐	Lying flat on your back
☐	☐	☐	Lying flat on your stomach
☐	☐	☐	Lying on your side with your knees bent

7. Do you have to rest during the day because of your pain? (Check appropriate box)
   - ☐ No
   - ☐ Half the day
   - ☐ A little
   - ☐ More than half the day

8. Have you ever been in a hospital for back, leg, neck, or arm pain? _____
   Number of times: _____
   Give dates: _____

9. Have you ever had a myelogram (x-ray of the spine with dye injection)? _____
   Number of times: _____
   Give dates: _____

10. Have you ever had an electromyogram (EMG)? _____
    Number of times: _____ Give dates: _____

11. Have you ever had neck or back surgery? _____
    Number of times: _____
    Give types and dates: _____
    _____

12. Have you ever been in the hospital for other medical problems? _____ Number of times: _____
    Describe and give dates: _____

13. Do you exercise on a regular basis?
    ☐ Yes ☐ No

14. Please list the medicines you are currently taking: _____
    _____

15. What other medical problems do you have? (Check appropriate boxes)
    - ☐ Diabetes
    - ☐ Stomach problems, ulcer, etc.
    - ☐ Arthritis
    - ☐ Heart problems
    - ☐ Gout
    - ☐ Epilepsy (fits)
    - ☐ Cancer
    - ☐ Other

16. Please list any allergies you have: _____
    _____

17. Do you have an attorney helping you?
    ☐ Yes ☐ No

18. Do you want a report sent to your attorney?
    ☐ Yes ☐ No

19. Do other members of your family have significant back or neck trouble? _____
    Who (relationship)? _____

20. What treatments have made your pain better? _____
    _____
    What treatments have made your pain worse? _____
    _____

21. What is the most aggravating thing about your pain? _____
    _____

22. What brought you to this office? _____
    _____

23. Please add any other information you would like to include, or additions to your answers to previous questions. _____
    _____
    _____
    _____
    _____

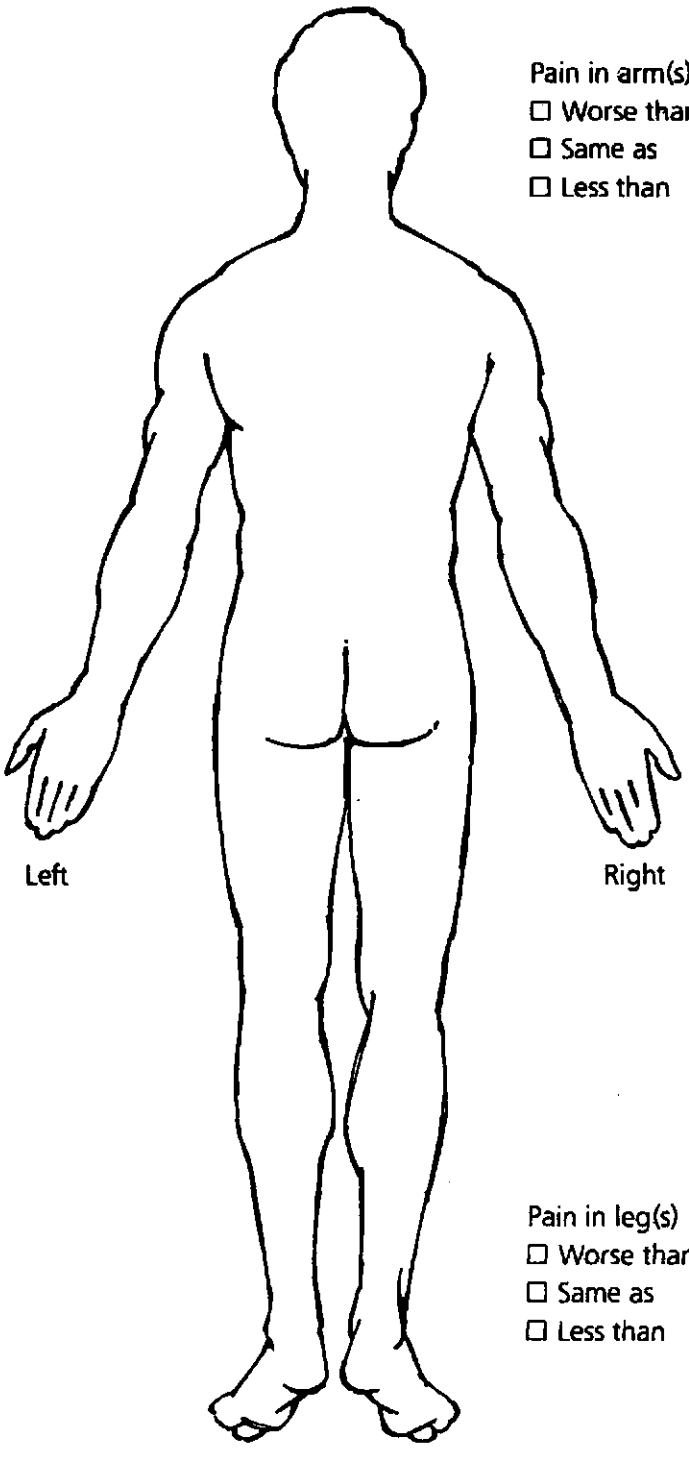
PATIENT PAIN DRAWING

Name: _____ Date: _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

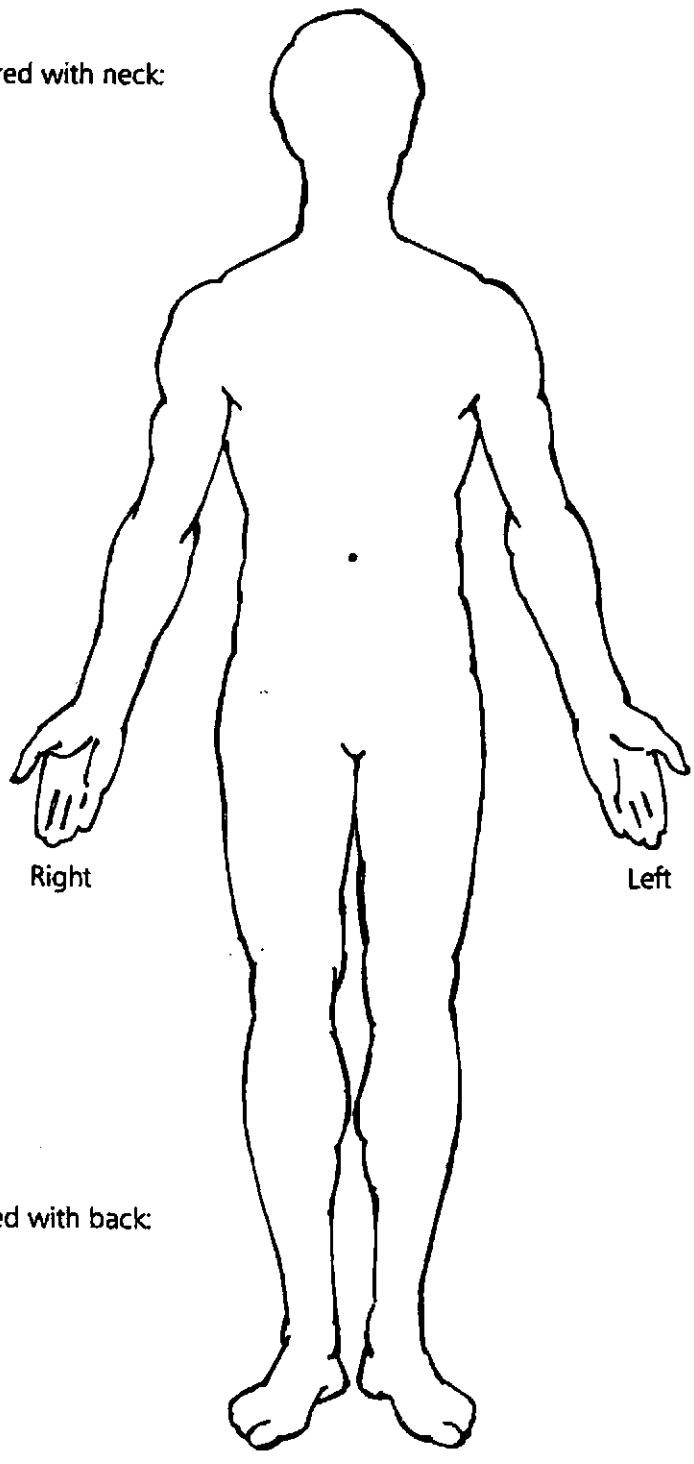
Aching	Numbness	Pins and needles	Burning	Stabbing	Other
▲ ▲ ▲	= = =	O O O	× × ×	/ / /	• • •

Back



Pain in arm(s) compared with neck:
- ☐ Worse than
- ☐ Same as
- ☐ Less than

Front



Pain in leg(s) compared with back:
- ☐ Worse than
- ☐ Same as
- ☐ Less than