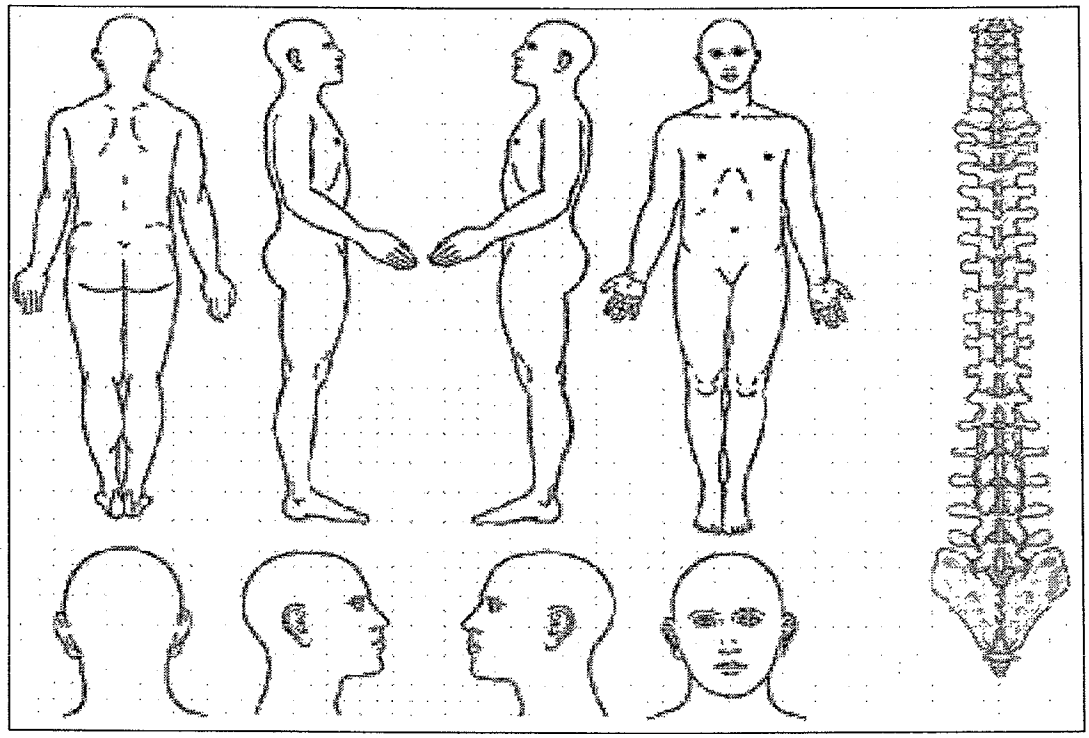
Patient Symptoms Report & Diagram

Name: _____ **Age:** _____ **Occupation:** _____ **Date:**___/___/___

Are you still working? □ Yes □ No **Last day on Job**_____

Mark these drawings according to where you hurt (ex: if the back of your neck has pain, circle the back of the neck, etc.). Include all affected areas.



Please circle the appropriate number below showing how bad your pain is:

Now:	No pain	1	2	3	4	5	6	7	8	9	10	Worst possible pain
At Worst:	No pain	1	2	3	4	5	6	7	8	9	10	Worst possible pain
At Best:	No pain	1	2	3	4	5	6	7	8	9	10	Worst possible pain

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

How did pain start? (Check appropriate box)

□ Suddenly □ Gradually □ Twisting □ Bending
□ Lifting □ Fall □ Pulling /Pushing □ Injured at work
□ Injured during sports □ Injured in auto accident □ No apparent cause

Have you had similar pain? □ Yes □ No □ Date ____/_____/_____

Have you been hospitalized for your pain problem? □ Yes □ No □ Date ____/_____/_____

What describes the nature of your symptoms?

□ Sharp □ Shooting □ Burning
□ Dull ache □ Numb □ Tingling

What activities make the pain worse/ Better/No difference?

	Better	Worse	No Difference	Comments
□ Exercise (during) or (after)				
□ Lying down				□ supine (lying down) □ right side □ left side
□ Sitting				□ How long
□ Standing				□ How long
□ Walking				□ Distance
□ Bending forward / backward				
□ Side Bending				
□ Coughing				
□ Sneezing				
□ Pain Medications, Aspirin or anti-inflammatory pills				
□ Other				

Have you received any of the following tests? **Date:**

□ **Diagnostic x-rays** □ **CT (computed tomography) scan** □ **Electromyogram (EMG)**
□ **Discogram** □ **MRI (magnetic resonance imaging)** □ **Others** _____

In general would you say your overall health right now is....

□ **Excellent** □ **Very good** □ **Good** □ **Fair** □ **Poor**

Medical History: (Circle Yes or No)

High Blood Pressure:	Y / N	**Cancer:**	Y / N	**Kidney Problems:**	Y / N
Cardiac Conditions:	Y / N	**Dizzy Spells:**	Y / N	**Gallbladder Problems:**	Y / N
Cardiac Pacemaker:	Y / N	**Vision Problems:**	Y / N	**Depression:**	Y / N
Circulation Problems:	Y / N	**Speech Problems:**	Y / N	**Anxiety:**	Y / N
Osteoporosis:	Y / N	**Strokes:**	Y / N	**Fractures:**	Y / N
Arthritis:	Y / N	**Seizures:**	Y / N	**Metal Implants:**	Y / N
Diabetes:	Y / N	**Allergies:**	Y / N	**Currently Pregnant:**	Y / N

Describe any other conditions or precautions: _____

Fall History Injury as a result of a fall in the past year? Y /N
Two or more falls in the last year? Y /N

Surgical History :

Body Region: _____ Surgery Type: _____ When (month/year): _____

Current Medications: Dosage: Reason Taking:

Patient signature: _____ **Date:** _____