

**PHYSIATRY INTAKE
INITIAL NECK AND BACK HISTORY QUESTIONNAIRE**

Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Temp.: _____

Please describe your problem: _____

When did this problem start?(approx): _____

Was there an injury?: _____

Have you had unexpected weight loss?: _____

Did this injury result in a lawsuit?: _____

Does the pain wake you from sleep?: _____

Is your bladder/urine function normal?: _____

How far can you walk?(city blocks): _____

Is your bowel/feces control normal? _____

PHYSICIAN ONLY:

Rad Pain- _____

N/P- _____

Weakness- _____

B/B- _____

Gait/Bal- _____

Meds- _____

PT- _____ CH/DO- _____ Accu.- _____

Brace- _____ Tens- _____

Injections: _____

Studies: _____

PE: _____

Assessment- _____

Plan: _____

WHERE IS YOUR PAIN NOW?

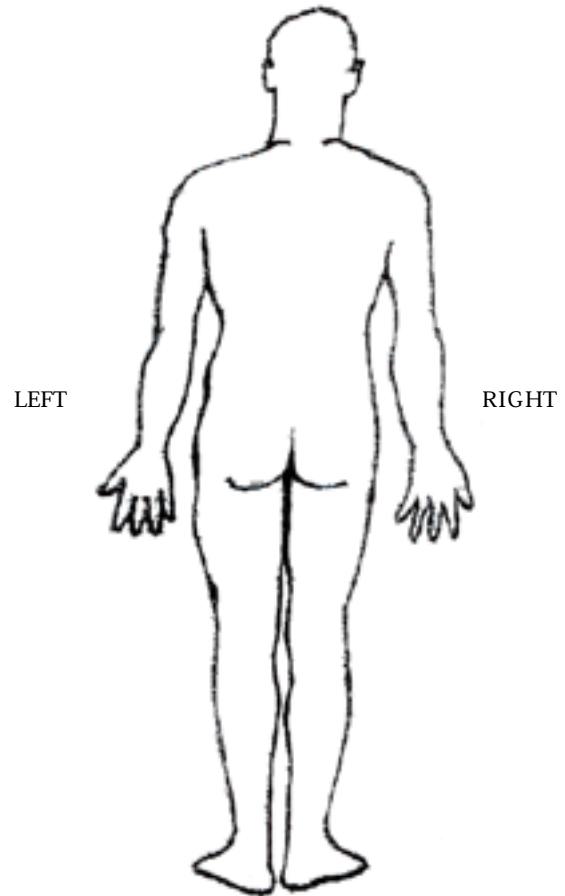
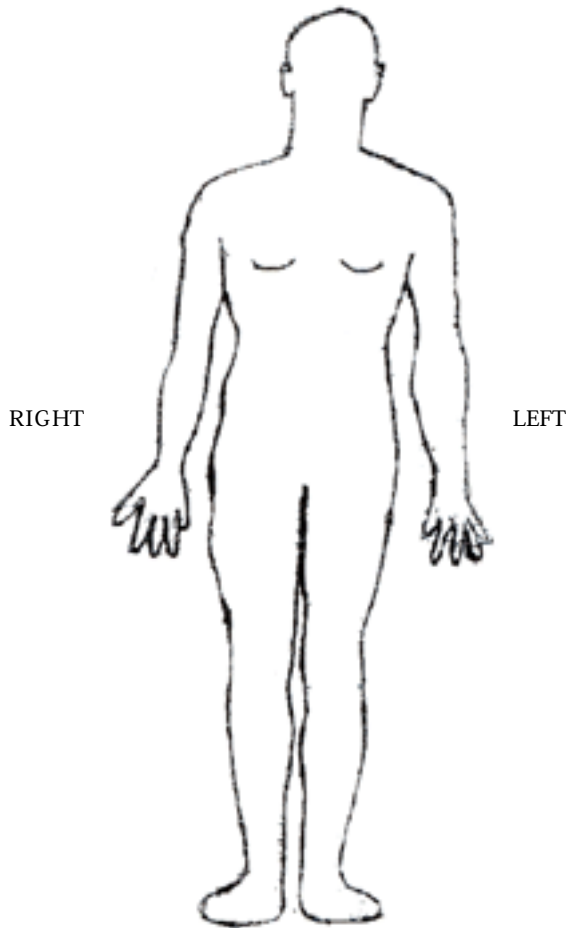
Using the appropriate symbols, mark all of the areas on your body where you feel the sensations described below

PAIN xxx

BURNING ++

TINGLING ---

NUMBNESS oooo



FRONT

BACK

My number one problem is:

_____ back/neck pain

_____ arm/leg pain

_____ numbness/tingling

_____ weakness

This page must be printed, filled out, and sent to our office prior to your visit.

PLEASE RATE YOUR PAIN:

0 = NO PAIN

10 = EXTREME PAIN

1. Right Now:	0	1	2	3	4	5	6	7	8	9	10
2. At Best:	0	1	2	3	4	5	6	7	8	9	10
3. At Worst:	0	1	2	3	4	5	6	7	8	9	10

WHAT MAKES YOUR PAIN WORSE?

- | | |
|-------------------------|-----------------------------|
| Sitting | Driving |
| Laying | Lifting |
| Walking | Raising arms above the head |
| Getting up from a chair | Other: |

WHAT MAKES YOUR PAIN BETTER?

- | | |
|-------------|-----------------------------|
| Sitting | Medication: |
| Laying Down | Heat or cold |
| Walking | Raising arms above the head |
| Other: | |

PRIOR DIAGNOSTIC TEST - Please indicate WHEN/WHERE:

X-Rays	Yes _____	No
MRI	Yes _____	No
CT Scan	Yes _____	No
Myelogram	Yes _____	No
Discogram	Yes _____	No
Other	_____	
	Yes _____	No

PRIOR TREATMENTS - Please indicate WHEN/WHERE

Medication	Yes _____	No
Injections	Yes _____	No
Surgery	Yes _____	No
Physical Therapy	Yes _____	No
Other	_____	
	Yes _____	No

DO YOUR SYMPTOMS LIMIT YOUR ABILITY TO:

- | | |
|----------------------|---------------|
| Walk to the bathroom | Cleaning |
| Walk further | Cooking |
| Combing your hair | Driving a car |
| Dressing | Shopping |

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

GENERAL SYMPTONS: (CURRENTLY OR WITH IN THE LAST YEAR)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> CHILLS/SWEATS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> HIVES | <input type="checkbox"/> STOMACH PAIN |
| <input type="checkbox"/> FEVER | <input type="checkbox"/> ANXIETY | <input type="checkbox"/> RASH | <input type="checkbox"/> EXTREME THIRST |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> INSOMNIA | <input type="checkbox"/> ITCHING | <input type="checkbox"/> NAUSEA |
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> LOSS OF APPETITE | <input type="checkbox"/> SORES | <input type="checkbox"/> BLOATING/GAS |
| <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> LOSS OF WEIGHT | <input type="checkbox"/> EASY BRUISING | <input type="checkbox"/> VOMITING BLOOD |
| <input type="checkbox"/> BLOOD IN URINE | | | |
| <input type="checkbox"/> PAINFUL URINATION | <u>MEN:</u> | <u>WOMEN:</u> | |
| <input type="checkbox"/> BLADDER/URINE ACCIDENTS | <input type="checkbox"/> ERECTILE DIFFICULTIES | <input type="checkbox"/> MENOPAUSE | |
| <input type="checkbox"/> BOWEL/FECAL ACCIDENTS | <input type="checkbox"/> PENILE SORES | <input type="checkbox"/> IRREGULAR MENSES | |
| | <input type="checkbox"/> PAINFUL INTERCOURSE | <input type="checkbox"/> PAINFUL INTERCOURSE | |

GENERAL CONDITIONS: (NOW OR IN THE PAST)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> CANCER | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> ALCOHOLISM |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DRUG DEPEND. |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> ANOREXIA/BULIMIA | <input type="checkbox"/> SERIOUS INFEC. |
| <input type="checkbox"/> RHEUMATOID DZ | <input type="checkbox"/> GOUT | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> SEX. TRANS. DZ |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> STOMACH ULCERS | <input type="checkbox"/> PSYCHIATRIC CARE | <input type="checkbox"/> AIDS/HIV |

PAST MEDICAL HISTORY: (PROBLEMS/CONDITIONS/DISEASES THAT YOU HAVE OR HAVE HAD IN THE PAST)

- | | |
|---|-------|
| <input type="checkbox"/> HEART PROBLEMS | _____ |
| <input type="checkbox"/> LUNG | _____ |
| <input type="checkbox"/> KIDNEY | _____ |
| <input type="checkbox"/> LIVER | _____ |
| <input type="checkbox"/> NEUROLOGIC | _____ |
| <input type="checkbox"/> RHEUMETOID | _____ |
| <input type="checkbox"/> BOWEL | _____ |
| <input type="checkbox"/> THYROID | _____ |
| <input type="checkbox"/> GENITO-URINARY | _____ |
| | _____ |

PAST SURGICAL HISTORY:

SURGERY	DATE	SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOSPITALIZATIONS: (BESIDES ABOVE SURGERIES)

FOR WHAT PROBLEM?	WHERE?	DATE
_____	_____	_____
_____	_____	_____

MEDICATIONS: (CURRENTLY)

NAME	DOSAGE	NAME	DOSAGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES: (ESPECIALLY TO MEDICATION)

MEDICATION	REACTION	MEDICATION	REACTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HABITS:

DO YOU SMOKE? _____ HOW MUCH PER DAY? _____

DO YOU DRINK ALCOHOL? _____ HOW MUCH/HOW OFTEN? _____

DO YOU USE OTHER DRUGS? _____ 3RD WORLD COUNTRY TRAVEL? _____

FAMILY HISTORY:

ARE YOU MARRIED? _____

HOW MANY CHILDREN DO YOU HAVE? _____ AGES: _____

DO ANY FAMILY MEMBERS HAVE OR HAVE HAD ANY SIGNIFICANT MEDICAL PROBLEMS? _____

OCCUPATIONAL HISTORY:

DO YOU CURRENTLY WORK? _____ OCCUPATION: _____

WHO REFERRED YOU TO OUR OFFICE? _____

WHO IS YOUR GENERAL PHYSICIAN? _____

TOWN: _____

WOMEN: IF YOU MAY BE PREGNANT BE SURE TO TELL THE DOCTOR OR THE TECHNITION PRIOR TO ANY X-RAYS.

I CERTIFY THAT THE ABOVE IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT'S SIGNATURE: _____

PHYSICIAN'S SIGNATURE _____