

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_

1. History of Present Illness

What is the problem you are being seen for today?

\_\_\_\_\_

Location – Where is the pain? \_\_\_\_\_

Severity – how severe is the pain? Circle one. (little pain) 1 2 3 4 5 6 7 8 9 (sever pain)

Duration – how long have you had the pain? \_\_\_\_\_ weeks/months/years

Associated signs/symptoms \_\_\_\_\_

2. Previous medical problems involving you (circle all that apply):

Cardiovascular: Heart attack High Blood pressure Heart rhythm problems Aneurysm  
Leg blood vessels problem Stroke Blood Clot

Respiratory: Asthma Emphysema Bronchitis Pneumonia

Gastrointestinal: Irritable Bowel Syndrome Heart Burn Ulcer Appendicitis Colitis Gallbladder  
GERD Reflux

Brain: Tumor Aneurysm Seizure Stroke Trauma

Spine: Disc Disease Trauma

Endocrine: Diabetes Thyroid Prostate

Cancer: Type: \_\_\_\_\_

Miscellaneous: Depression Anxiety Disorder Bleeding Problems Other: \_\_\_\_\_

Arthritis: Rheumatoid Gout Ankylosis Spondylitis

Other: \_\_\_\_\_

3. Please list all prior hospitalizations and surgeries:

<u>Year</u>	<u>Operation/Illness</u>	<u>Year</u>	<u>Operation/Illness</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. List all medications you are now taking or have taken in the last two weeks:

<u>Medicine</u>	<u>Dose / Time per day</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\*\*\*\*\* Please list any allergies (to drugs) \_\_\_\_\_

5. Any major / persistent problems with (circle all that apply):

Recent weight change	Abdomen Pain / Heartburn	Spitting up blood
Fever	Frequent / Difficulty Urination	Sinus Drainage
Fatigue	Joint Stiffness	Asthma / wheezing
Headaches	Weakness of muscles / joints	Diabetes
Chest pain or angina pectoris	Numbness or tingling	Unexplained fevers
Palpitations	Nervousness	Difficulty sleeping
Shortness of breath	Bleeding / bruising tendency	Night sweats
Swelling of feet / ankles	Phlebitis	Stomach pain
Chronic / frequent cough	Hay fever	Blood in stools

6. Do you use tobacco products? Yes No \_\_\_\_\_ packs per day?
7. Alcohol Intake: None Beer Wine Alcohol Amount per week \_\_\_\_\_
8. Circle One: Married Single Divorce Widow Number of kids \_\_\_\_\_
9. Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs.

Family History of medical problems: \_\_\_\_\_

**Back / Neck History:**

10. Did you injure your back / neck? No Yes If so, when and how:  
 \_\_\_\_\_  
 \_\_\_\_\_
- Is you injury work related? No Yes
11. Where are you employed? \_\_\_\_\_ Position / Title \_\_\_\_\_
12. Have you had previous back / neck pain? No Yes When? \_\_\_\_\_
13. Have you had previous leg / arm pain? No Yes When? \_\_\_\_\_
14. Do you have: leg / arm weakness? No Yes Balance Problems? No Yes
15. Have you missed work because of you back / neck? No Yes If so, how much time? \_\_\_\_\_
16. Please answer the following questions regarding your pain.  
 Approximately how many minutes can you ride in a car without pain? \_\_\_\_\_  
 Approximately how many minutes can you sit in a chair without pain? \_\_\_\_\_  
 Approximately how many minutes can you stand in one place without pain? \_\_\_\_\_  
 I can walk \_\_\_\_\_ miles / blocks / yards without stopping.
17. Please circle the appropriate choice.  
 I *have / have never / have frequently* lost control of my bowels.  
 I *have / have never / have frequently* lost control of my bladder.
18. When you read a sentence that describes you, put an "X" next to it.  
 \_\_\_\_\_ I change positions frequently to try and get my back / neck comfortable.  
 \_\_\_\_\_ Lying down provides relief for my back / neck.  
 \_\_\_\_\_ Arching my back makes my back pain worse.  
 \_\_\_\_\_ Curling up in a ball / fetal position helps my back pain.  
 \_\_\_\_\_ Pain disturbs my ability to get restful sleep.  
 \_\_\_\_\_ My walking is more unsteady now than five years ago.  
 \_\_\_\_\_ I frequently drops things because my hands go numb.

**Treatment:**

19. Please list physicians you have seen for your back / neck pain, along with the appropriate date(s):

Doctor's Name	Location	Approx. Dates

20. Put a check next to each type of treatment you have had for your back / neck in the past. Then check the column that best describes the effect of the treatment.

<u>TREATMENT</u>	<u>EFFECT OF TREATMENT</u>	
<input type="checkbox"/> Hot packs/ice/ultrasound	<input type="checkbox"/> Helped	<input type="checkbox"/> Made worse
<input type="checkbox"/> Massage	<input type="checkbox"/> Helped	<input type="checkbox"/> Made worse
<input type="checkbox"/> TENS unit	<input type="checkbox"/> Helped	<input type="checkbox"/> Made worse
<input type="checkbox"/> Body mechanics training	<input type="checkbox"/> Helped	<input type="checkbox"/> Made worse
<input type="checkbox"/> Strengthening exercises	<input type="checkbox"/> Helped	<input type="checkbox"/> Made worse
<input type="checkbox"/> Bed rest	<input type="checkbox"/> Helped	<input type="checkbox"/> Made worse
<input type="checkbox"/> Soft back brace	<input type="checkbox"/> Helped	<input type="checkbox"/> Made worse
<input type="checkbox"/> Rigid back brace	<input type="checkbox"/> Helped	<input type="checkbox"/> Made worse
<input type="checkbox"/> Cervical Traction	<input type="checkbox"/> Helped	<input type="checkbox"/> Made worse
<input type="checkbox"/> Other _____		

Have you tried Chiropractic treatments?      Yes    No  
 If so,    Date: \_\_\_\_\_      Number of treatments: \_\_\_\_\_      Helped:      Yes    No

Have you tried epidural injections?      Yes    No  
 If so,    Date: \_\_\_\_\_      Number of treatments: \_\_\_\_\_      Helped:      Yes    No

21. If you have had any of the following studies, please indicate the appropriate date it was performed.

Myelogram	Date: _____	Facility: _____
Discogram	Date: _____	Facility: _____
X-rays	Date: _____	Facility: _____
EMG	Date: _____	Facility: _____
MRI	Date: _____	Facility: _____
Bone Scan	Date: _____	Facility: _____
Dexa Scan	Date: _____	Facility: _____

22. Mark the areas on your body where you now feel your typical pain. Include all affected areas. Use the appropriate symbols indicated below.

ACHE >>>>                      NUMBNESS ===                      PINS & NEEDLES 0000  
 STABBING //////////////  
 >>>>                                      ===                                      0000                                      //////////  
 >>>>      **FRONT**                      ===                                      **BACK**                      0000                                      //////////



Physician use only:

Any changes to above H & P?    Yes    No      Date: \_\_\_\_\_      F. Paul DeGenova, DO  
 Any changes to above H & P?    Yes    No      Date: \_\_\_\_\_      F. Paul DeGenova, DO