

1. When did current pain start? _____

2. How did symptoms start? Please describe.

3. Have you had similar complaints in the past? If yes, please explain.

4. Is your present pain there all the time? YES _____ or NO _____

5. Does the following affect your pain:

	YES	NO
Lifting		
Bending		
Standing		
Sitting		
Coughing		
Sneezing		
Lying flat on your back		
Lying flat on your stomach		
Lying on sides with knees bent		
Morning		
During the day		
Night		

6. Do you have to rest on a daily basis? If so, how many minutes or hours?

7. Has this incident caused you to have:

	YES	NO
Myelogram		
EMG		
CAT Scan		
MRI Scan		
Epidural Injections		
Facet Injections		
Trigger Point Injections		
Surgery		

8. Is there a Family History of spine or joint problems? If so, please describe.

9. Have any treatments improved your condition? If so, which?

10. Are you working at this time? If so, what is your current job?

11. Do you have a lawyer involved in this case? _____
 If so, what is his or her name? _____

Respiratory Wheezing Bloody sputum Excessive cough Night sweats Pain with breathing Shortness of breath with little exercise or rest Other _____ _____	Cardiovascular Chest pain Abnormal or fast heartbeat Calf cramps when walking Varicose veins Excessive sensitivity of toes & fingers to cold Frequent or marked swelling of ankles & feet Other _____ _____	Gastrointestinal Digestion difficulties Frequent nausea or vomiting Bloody vomitus Lack or loss of appetite Stomach or abdominal pain frequent belching Frequent loose bowel or recurring diarrhea Bloody stool, black stool Hemorrhoids Frequent or severe constipation Other _____
Genitourinary Urinary incontinence Bloody urine Increase in urination frequency Narrow urine stream Flank pain Urination urgency Difficulty starting or passing urine Other _____	Genitourinary-Male Penile pain Abnormality of testicles Scrotal swelling Infection or sores Prostatitis Penile discharge Bleeding following intercourse Difficulty in sexual function Other _____	Genitourinary-Female Breast discharge, swelling, lumps Nipple changes or irritations Vaginal pain Infection, discharge or itch Known uterine fibroids/tumors Tubal infections Abnormal or painful menstrual flow Infertility or difficulty conceiving Change in body hair distribution Difficulty in sexual function Other _____
Emotional/Psychological Insomnia Depression Recurrent feeling of loneliness/hopelessness Excessive worry Severe tension Feeling of worthlessness Nervous exhaustion Frequent crying	Frequent nightmares Hysterical attacks Constant unhappiness Other _____	Neurological Severe or frequent headaches Unusual head or neck lesion Dizziness Fainting spells Severe lapses of memory Shaking or twitching spells Paralysis of limbs Blackouts Other _____

10. Has any blood relative had any of the following? (Please circle and list which relative)

Heart trouble	Syphilis	Diabetes	Cancer	Arthritis	Asthma
Tuberculosis	Epilepsy	Kidney trouble	High blood pressure	Stomach trouble	

11. What is your highest level of education? (Please circle)

High school	Bachelors	Masters	Doctorate	Other _____
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12. Have you ever been in the military? Yes No

13. Are you: Single? Married? Widowed? Divorced?

14. Any children? Yes No If yes, how many male _____ female _____

15. What is your occupation? _____

16. Where were you born? _____

17. How many brothers _____ and sisters _____ do you have?

NAME _____

DATE _____

1. What operations have you had?

Date	Type	Hospital	Surgeon	Complications

2. Have you had, or do you have, any of the following illnesses or disease? (PLEASE CIRCLE)

- | | | | |
|-------------------------------|---------------------|-------------------|---------------------------|
| Cancer | Poor blood flow | Gallstones | Convulsion |
| Cataracts | Excessive Bleeding | Jaundice | Nervous Breakdown |
| Glaucoma | Rheumatic Fever | Liver Cirrhosis | Concussion |
| Emphysema | High Blood Pressure | Bowel Obstruction | Migraine/Tension Headache |
| Asthma | Heart Attack | Hepatitis | Stroke |
| Tuberculosis | Heart Murmur | Ulcer | Nerve Disease |
| Sinus Disease | Heart Failure | Hernia | Anemia (Low Blood Count) |
| Bronchitis | Thyroid Disease | Urinary Infection | Blood Transfusion |
| Phlebitis/Leg Clot | Diabetes | Kidney Disease | Other _____ |
| Pulmonary Embolus (Lung Clot) | | Kidney Stones | |

3. Have you ever been hospitalized at any time aside from surgery? YES NO (IF SO, FOR WHAT?)

4. Do you take any pills, medicine or injections on a regular basis? YES NO (IF YES, PLEASE LIST)

5. Are you allergic to any medication? YES NO (IF SO, LIST THE DRUGS & REACTION YOU HAD)

6. Have you had any fractures, sprains, arthritis symptoms or other orthopedic conditions?
Yes No (IF YES, PLEASE LIST)

7. Please indicate your approximate use or intake of the following:

	Per Day	Per Week
Coffee	_____	_____
Tobacco Products	_____	_____
Alcoholic Beverages	_____	_____

8. Any weight changes in the past year? Yes No IF SO, WHY?

9. Do you have any of the following? IF SO, PLEASE CIRCLE

EYE & VISION

- Loss or change of vision
- Eye pain or redness
- Excessive Watering
- Double Vision
- Other _____

EARS & HEARING

- Loss of Hearing
- Buzzing or noises in ear
- Ear Infection/Drainage
- Other _____

NOSE & THROAT

- Hoarseness
- Excessive Sneezing
- Blocked Nasal Passages
- Nosebleeds
- Difficulty Swallowing
- Other _____

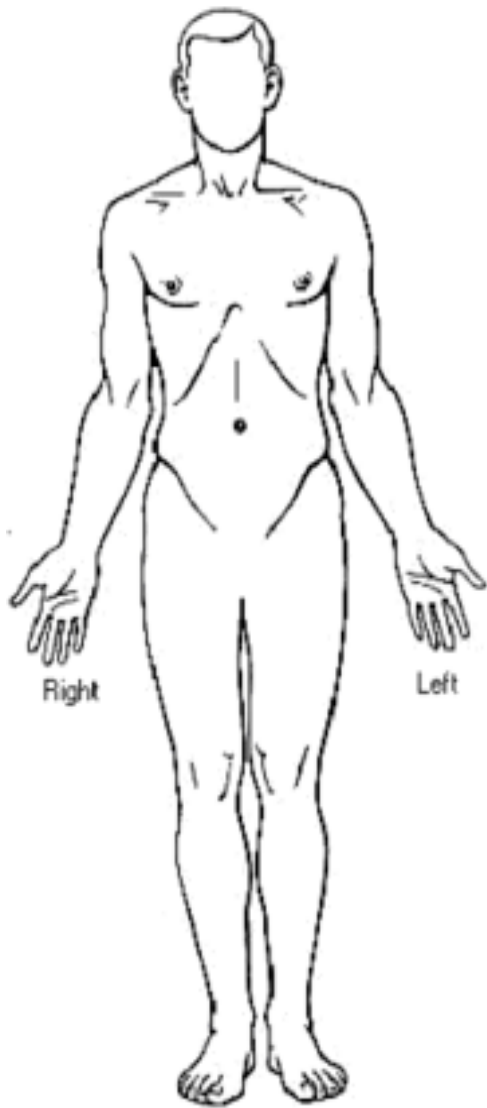
USING THE SYMBOLS GIVEN BELOW, MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. INCLUDE ALL AFFECTED AREAS. JUST TO COMPLETE THE PICTURE, PLEASE DRAW IN YOUR FACE.

PAIN
XXX

NUMBNESS
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PINS & NEEDLES
OOOOO

Front



Back

