# Medical History

**Name**: _____ **Today's Date:** _____
**Onset/Injury Date:** _____ **Surgery Date:** _____
**Referring Physician:** _____ **Next Doctors Appt:** _____
**Is this: Work related? Employer**_____ **Auto Related?** _____ **State:**_____
**Describe your current condition and how it began:**

_____

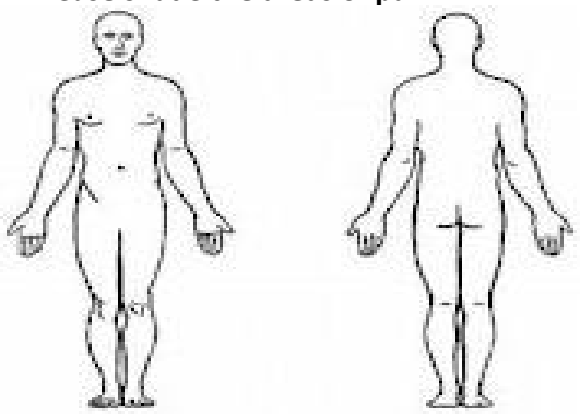
_____

**Have you had any tests for this condition?** ☐ X-ray ☐ MRI ☐ Injections ☐ CT scan:
**If yes date:** _____ **Office**: _____

**How is your condition changing?**
☐ Improving ☐ No change ☐ Decreasing

**In the past week, how much has your pain interfered with your daily activities? (I.e. Household chores, work, social activities, etc.)** 0 1 2 3 4 5 6 7 8 9 10 Unable

**Please shade the areas of pain:**



**Pain: Where?** _____
**What makes the pain worse?** _____
**What makes the pain better?** _____
**Numbness: YES/NO, where:** _____
**What increases numbness?** _____
**What decreases numbness?** _____

**Rate your current pain on a scale of 0 -10** (0 = no pain/discomfort, 10 = worst pain imaginable) _____
**Rate your pain at its best**_____ **Rate your pain at its worst**_____

**Circle the nature of your pain:** Sharp Achy Numb Burning Throbbing Shooting

**How often are your symptoms present?**
☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% if the day) ☐ Intermittently (0-25% of the day)

**In general, how is your overall health right now:**
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

**Please check all of the following that apply:**
☐ Asthma ☐ Diabetes ☐ High Blood Pressure ☐ Stroke
☐ Epilepsy ☐ Pacemaker ☐ Dizziness/ Fainting ☐ Back Injury
☐ Fracture ☐ Arthritis ☐ Cancer ☐ Bladder Problems
☐ Currently Pregnant: # Weeks____ ☐ Other: _____