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:

_____

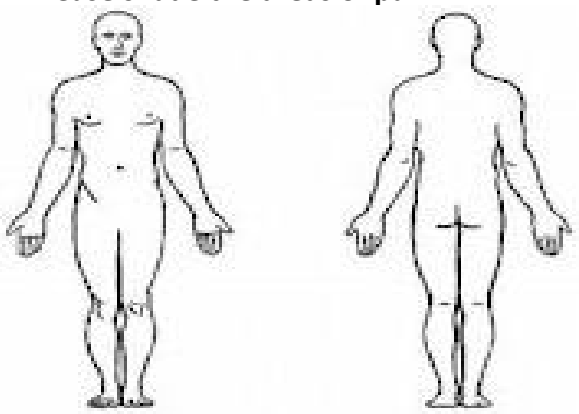
_____

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 ☐ Worsening

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 ☐ Seizures
☐ Epilepsy ☐ Pacemaker ☐ Dizziness/ Fainting ☐ Back Injury
☐ Fracture ☐ Arthritis ☐ Cancer ☐ Bladder Problems
☐ Currently Pregnant: # Weeks____ ☐ Other: _____