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Complete History & Physical Examination

Please complete the following questions pertaining to your health history. If it does not apply to you please write NONE.

Patient Name:____ Date of Birth:_______________ Age:_________

Place of Birth:_________________________________ Height:__________ Weight:________ Handed: Right Left

Reason for visit:____

When did your symptoms first appear?____

Accident: (Y) (N) Description:____

Primary Care Physician:____ Phone:____________________________

Other Specialists Seen: 1.____Date:______________________

2.____ Date:______________________

3.____ Date:______________________

Past Medical History

List all past and present medical problems (eg. blood pressure, cardiac disease, diabetes, glaucoma, cancer):

1.____

2.____

3.____

4.____

5.____

ANY & ALL Surgeries:

1._____________________________________ Date:_______________ Hospital:___________________________

2._____________________________________ Date:_______________ Hospital:___________________________

3._____________________________________ Date:_______________ Hospital:___________________________

4._____________________________________ Date:_______________ Hospital:___________________________

5._____________________________________ Date:_______________ Hospital:___________________________

Accidents: Motor Vehicle, Slip & Fall, ect. Body part injured

1.____ Date:______________________

2.____ Date:______________________

3.____ Date:______________________

Medications

Medication Allergies: Please write none if no allergies

1. ______________________________ Reaction: ______________________________
2. ______________________________ Reaction: ______________________________
3. ______________________________ Reaction: ______________________________

Current Medications, including herbs, vitamins and over the counter medications:

1. ______________________ Dosage: __________ Schedule: ________________
2. ______________________ Dosage: __________ Schedule: ________________
3. ______________________ Dosage: __________ Schedule: ________________
4. ______________________ Dosage: __________ Schedule: ________________
5. ______________________ Dosage: __________ Schedule: ________________
6. ______________________ Dosage: __________ Schedule: ________________
7. ______________________ Dosage: __________ Schedule: ________________
8. ______________________ Dosage: __________ Schedule: ________________
9. ______________________ Dosage: __________ Schedule: ________________
10. ______________________ Dosage: __________ Schedule: ________________

Patient Name ______________________

Review of Systems

Have you ever had any of the following? Please CLICK YES OR NO

Ears/Nose/Mouth/Throat

Difficulty swallowing	Yes	No
Hearing loss	Yes	No
Hoarseness	Yes	No
Persistent cough	Yes	No
Ringing in the ears	Yes	No

Eyes

Wear glasses or contacts	Yes	No
Double vision	Yes	No
Vision flashes or halos	Yes	No

Lungs/Heart

Asthma	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Shortness of breath	Yes	No
Tuberculosis	Yes	No
Chest pain	Yes	No
Irregular heart beat	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No
Low blood pressure	Yes	No
Poor circulation	Yes	No
Rapid heart beat	Yes	No
Swelling of ankles	Yes	No

Hematologic/Lymphatic

Anemia	Yes	No
Easy bruising	Yes	No
Prolonged bleeding	Yes	No

Gastrointestinal

Ulcers	Yes	No
Hepatitis	Yes	No
Nausea	Yes	No

Genitourinary

Lack of bladder control	Yes	No
Bladder urgency	Yes	No

Endocrine

Rapid weight loss	Yes	No
Rapid weight gain	Yes	No
Hyperthyroidism	Yes	No
Multiple broken bones	Yes	No
Menopause	Yes	No
Hypothyroidism	Yes	No
Discharge from nipple	Yes	No
Diabetes	Yes	No

Musculoskeletal

Arthritis	Yes	No
Osteoporosis	Yes	No

Neurological

Fainting	Yes	No
Headaches	Yes	No
Numbness in arms	Yes	No
Numbness in legs	Yes	No
Seizures	Yes	No
Tingling in hands	Yes	No
Tingling in feet	Yes	No

Psychiatric

Anxiety	Yes	No
Depression	Yes	No
Panic attacks	Yes	No
Restlessness	Yes	No

Patient Name ____________________

Family History

Has any BLOOD RELATIVE ever had any of the following? If yes, please list relative.

Cancer	Yes	No	_______________
Diabetes	Yes	No	_______________
Stroke	Yes	No	_______________
Suicide	Yes	No	_______________
Depression	Yes	No	_______________
Gout	Yes	No	_______________
Lupus	Yes	No	_______________
High blood pressure	Yes	No	_______________
Bleeding tendency	Yes	No	_______________
Convulsions	Yes	No	_______________
Heart trouble	Yes	No	_______________
Tuberculosis	Yes	No	_______________
Arthritis	Yes	No	_______________

Social History

Martial status:______________________ How many years if married:_________ How many children:_________

Present occupation:____ Years:_____________________

Previous occupation:____ Years:_____________________

Previous occupation:____ Years:_____________________

Disabled: Yes No Date last worked:___________________

Smoke:	Yes	No	Amount:______________________	Stopped______________
Caffeine:	Yes	No	Amount:___________________	___Stopped_______________
Alcohol:	Yes	No	Amount:___________________	___Stopped_______________
Other drugs:	Yes	No	Amount:___________________	___Stopped_______________

What do you do for exercise & frequency ____

Patient Name

Low Back Disability Index Questionnaire

Name:____ Date completed:___________________

This questionnaire has been designed to give us information as to how your leg or back pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just mark the box that indicates the statement which **most clearly describes your problem**. Please note 2 kilometers is approximately 1.2 miles, 1 kilometer is approximately 0.6 miles and 0.3 miles.

Section 1: Pain Intensity
☐ I have no pain at the moment
☐ The pain is very mild at the moment
☐ The pain is moderate at the moment
☐ The pain is fairly severe at the moment
☐ The pain is very severe at the moment
☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (washing, dressing, etc.)
☐ I can look after myself normally without causing extra pain
☐ I can look after myself normally but it causes extra pain
☐ It is painful to look after myself and I am slow and careful
☐ I need some help but can manage most of my personal care
☐ I need help every day in most aspects of self-care
☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting
☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights but it gives me extra pain
☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed, e.g. on table
☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently placed
☐ I can only lift very light weights
☐ I cannot lift or carry anything

Section 4: Walking
☐ Pain does not prevent me walking any distance
☐ Pain prevents me from walking more than 2 kilometers
☐ Pain prevents me from walking more than 1 kilometer
☐ Pain prevents me from walking more than 500 meters
☐ I can only walk using a stick or crutches
☐ I am in bed most of the time

Section 5: Sitting
☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour
☐ Pain prevents me from sitting more than 30 minutes
☐ Pain prevents me from sitting more than 10 minutes
☐ Pain prevents me from sitting at all

Section 6: Standing
☐ I can stand as long as I want without extra pain
☐ I can stand as long as I want but it gives me extra pain
☐ Pain prevents me from standing for more than 1 hour
☐ Pain prevents me from standing for more than 30 minutes
☐ Pain prevents me from standing for more than 10 minutes
☐ Pain prevents me from standing at all

Section 7: Sleeping
☐ My sleep is never disturbed by pain
☐ My sleep is occasionally disturbed by pain
☐ Because of pain I have less than 6 hours of sleep
☐ Because of pain I have less than 4 hours of sleep
☐ Because of pain I have less than 2 hours of sleep
☐ Pain prevents me from sleeping at all

Section 8: Social Life
☐ My social life is normal and gives me no extra pain
☐ My social life is normal but increases the degree of pain
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports
☐ Pain has restricted my social life and I do not go out as often
☐ Pain has restricted my social life to my home
☐ I have no social life because of pain

Section 9: Traveling
☐ I can travel anywhere without pain
☐ I can travel anywhere but it gives me extra pain
☐ Pain is bad but I manage journeys over 2 hours
☐ Pain restricts me to journeys of less than 1 hour
☐ Pain restricts me to short necessary journeys less than 30 minutes
☐ Pain prevents me from traveling except to receive treatment

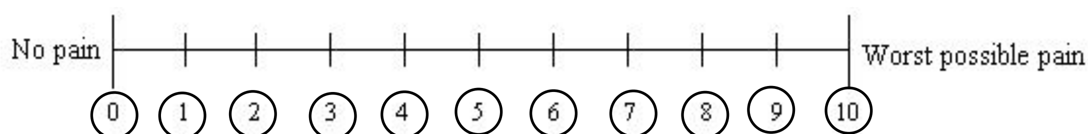
Section 10: Employment/Homemaking
☐ My normal homemaking/job activities do not cause pain
☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me
☐ I can perform most of my homemaking/job activities, but pain prevents me from performing more physically stressful activities, e.g. lifting, vacuuming, etc
☐ Pain prevents me from doing anything but light duties
☐ Pain prevents me from doing even light duties
☐ Pain prevents me from performing any job or homemaking chores

Low Back Visual Analog Scale

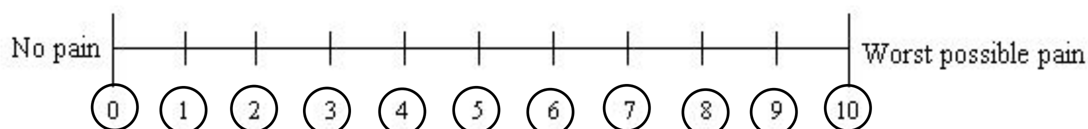
Name:____ Date completed:____________________

Mark the pain level that describes most closely the pain you are experiencing based on the questions asked. Mark a vertical line through the scale at the point that you feel best indicates your pain, whereas the far left side of the scale equals no pain and the far right side of the scale equals the worst possible pain

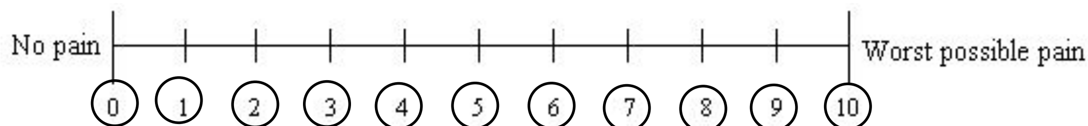
1. Please rate the severity of **leg pain** you are experiencing at this moment.



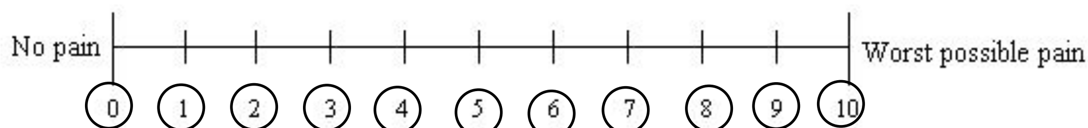
2. Please rate the severity of **back pain** you are experience at this moment.



3. Please rate the average severity of **leg pain** you experienced in the last 24 hours.



4. Please rate the average severity of **back pain** you experienced in the last 24 hours.



Neck Disability Index Questionnaire

Name:____ Date completed:__________________

This questionnaire has been designed to give us information as to how your neck pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just mark the box that indicates the statement which **most clearly describes your problem**.

Section 1: Pain Intensity
☐ I have no pain at the moment
☐ The pain is very mild at the moment
☐ The pain is moderate at the moment
☐ The pain is fairly severe at the moment
☐ The pain is very severe at the moment
☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (washing, dressing, etc.)
☐ I can look after myself normally without causing extra pain
☐ I can look after myself normally but it causes extra pain
☐ It is painful to look after myself and I am slow and careful
☐ I need some help but can manage most of my personal care
☐ I need help every day in most aspects of self-care
☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting
☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights but it gives me extra pain
☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed, e.g. on table
☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently placed
☐ I can only lift very light weights
☐ I cannot lift or carry anything

Section 4: Reading
☐ I can read as much as I want to with no neck pain
☐ I can read as much as I want with slight neck pain
☐ I can read as much as I want with moderate neck pain
☐ I can’t read as much as I want because of moderate neck pain
☐ I can hardly read at all because of severe neck pain
☐ I cannot read at all

Section 5: Headache
☐ I have no headache
☐ I have slight headaches which come infrequently
☐ I have moderate headaches, which come infrequently
☐ I have moderate headaches, which come frequently
☐ I have severe headaches, which come frequently
☐ I have headaches almost all the time

Section 6: Concentration
☐ I can concentrate fully when I want to with no difficulty
☐ I can concentrate fully when I want to with slight difficulty
☐ I have a fair degree of difficulty in concentrating when I want to
☐ I have a lot of difficulty in concentrating when I want to
☐ I have a great deal of difficulty in concentrating when I want to
☐ I cannot concentrate at all

Section 7: Work
☐ I can do as much as I want to
☐ I can only do my usual work but no more
☐ I can do most of my work, but no more
☐ I cannot do my usual work
☐ I can hardly do any work at all
☐ I cannot do any work at all

Section 8: Driving
☐ I can drive my car without any neck pain
☐ I can drive my car as long as I want with slight pain in my neck
☐ I can drive my car as long as I want with moderate neck pain
☐ I cannot drive my car as long as I want because of moderate neck pain
☐ I can hardly drive at all because of severe neck pain
☐ I cannot drive my car at all

Section 9: Sleeping
☐ I have no trouble sleeping
☐ My sleep is slightly disturbed (less than 1 hour sleep loss)
☐ My sleep is mildly disturbed (1 – 2 hours sleep loss)
☐ My sleep is moderately disturbed (2 – 3 hours sleep loss)
☐ My sleep is greatly disturbed (3 – 5 hours sleep loss)
☐ My sleep is completely disturbed (5 – 7 hours sleep loss)

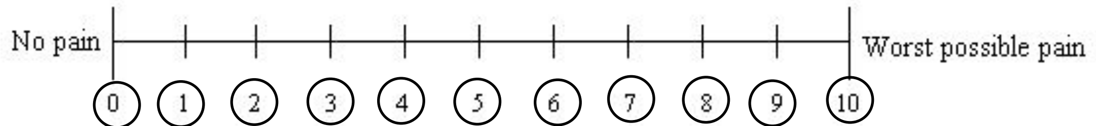
Section 10: Recreation
☐ I am able to engage in all my recreational activities with no neck pain at all
☐ I am able to engage in all my recreational activities with some neck pain
☐ I am able to engage in most but not all of my usual recreational activities because of neck pain
☐ I am able to engage in a few of my usual recreational activities because of neck pain
☐ I can hardly do any recreational activities because of neck pain
☐ I cannot do any recreational activities at all

Neck Visual Analog Scale

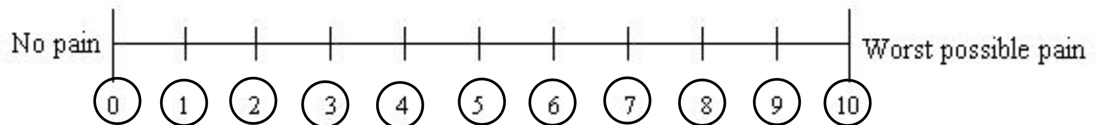
Name:____ Date completed:________________

Mark the pain level that describes most closely the pain you are experiencing based on the questions asked. Mark a vertical line through the scale at the point that you feel best indicates your pain, whereas the far left side of the scale equals no pain and the far right side of the scale equals the worst possible pain

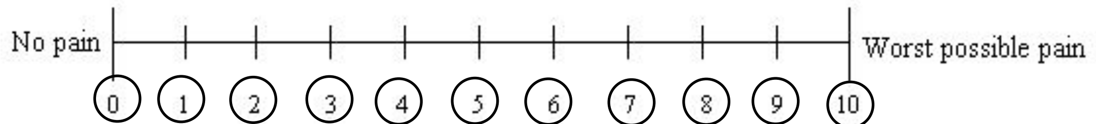
1. Please rate the severity of **arm pain** you are experiencing at this moment.



2. Please rate the severity of **neck pain** you are experiencing at this moment.



3. Please rate the average severity of **arm pain** you experienced in the last 24 hours.



4. Please rate the average severity of **neck pain** you experienced in the last 24 hours.