

GEM CITY BONE & JOINT

Please fill out these forms completely!

We know that filling out these forms can be difficult - but please complete them carefully. Your accurate responses will give us a better understanding of you and your health. From this information, we can provide you the best care possible.

Please be careful to follow the directions in each section. Clearly mark the check boxes and fill in the blanks where indicated.
Thank you for helping us to know you better!

Date: _____

Patient Name: _____
(please print)

Gender: Male Female

Date of Birth: _____
(month/day/year)

Current Age: _____

PAIN DIAGRAM

Please mark the areas where you feel the following sensations. Pay attention to right and left sides.

<p>Ache ^^^^^ ^^^^^ ^^^^^</p> <p>Numbness OOOO OOOO OOOO</p> <p>Pins & Needles ===== ===== =====</p> <p>Burning XXXX XXXX XXXX</p> <p>Stabbing ///// ///// /////</p>	<p>The diagram consists of two human silhouettes. The left silhouette is a front view, with the right side of the body labeled 'RIGHT' and the left side labeled 'LEFT'. The right silhouette is a back view, with the left side of the body labeled 'LEFT' and the right side labeled 'RIGHT'. Below the front view is the label 'FRONT' and below the back view is the label 'BACK'.</p>
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Patient's initials _____ Date _____

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FACTORS OF COMPLAINT

What do you want to happen as a result of this visit?

How and when did your problem begin? (Please mark each answer that applies to your neck/back pain.)

- I don't know how it began.
- It comes and goes.
- I've had it a long time. (____ years)
- Injury (date of injury _____) On the job? Yes No
- Please explain how the injury happened.

Are you currently in litigation with regard to your back pain?

- Yes No

Have you been laid off from your job? Yes No N/A

How bad is your pain? Place an "X" (—X—) on each of the lines below to indicate your pain.

How bad is your **low back** pain?

No pain-----**Worst possible**

How bad is your **leg** pain?

No pain-----**Worst possible**

How bad is your **middle back** pain?

No pain-----**Worst possible**

How bad is your **neck** pain?

No pain-----**Worst possible**

How bad is your **arm** pain?

No pain-----**Worst possible**

Do you have any of the following problems?

(Please check your answer.)

Is your pain worse at night? Yes No

Does your pain awaken you from sleep? Yes No

Does coughing affect your pain? Yes No

Do your legs tire/hurt if you walk too far? Yes No

If YES, how far can you walk?

- Less than 1 block 1-3 blocks More than 3 blocks

Is this relieved by resting your legs? Yes No

Is this relieved by bending forward? Yes No

Bladder Control (urine):

- No problem
- Can't empty bladder
- Loss of urine (accidents)

Bowel Control:

- No problem
- Constipation
- Loss of control (accidents)

How does each of the following affect your pain? (check your answer)

Sitting	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Standing	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Walking	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Lying down	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Rising from chair	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Physical activity	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Heat	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	<input type="checkbox"/> Don't know
Cold	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	<input type="checkbox"/> Don't know
Massage	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	<input type="checkbox"/> Don't know

Patient's initials _____ Date _____

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PREVIOUS TREATMENT

We need to know about the treatments you have already received for your current back/neck pain. If YES, did it make your condition better or worse?

Have you had:

Chiropractic care Better Worse
 Physical therapy Better Worse
 Injections Better Worse
 Psychological consultation Better Worse
 Other: _____ Better Worse

For your current back/neck pain, please mark the boxes for the timeframe that any tests were done.

	<u>< 6 mo</u>	<u>< 12 mo</u>
X-rays	<input type="checkbox"/>	<input type="checkbox"/>
MRI scan	<input type="checkbox"/>	<input type="checkbox"/>
CT scan	<input type="checkbox"/>	<input type="checkbox"/>
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>
Discogram	<input type="checkbox"/>	<input type="checkbox"/>
EMG/NCV(nerve test)	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had surgery on your back or neck?

Yes No **If YES, complete the following:**

1) Type of surgery _____
 Date _____
 Surgeon _____
 Did it make your pain Better or Worse?

2) Type of surgery _____
 Date _____
 Surgeon _____
 Did it make your pain Better or Worse?

3) Type of surgery _____
 Date _____
 Surgeon _____
 Did it make your pain Better or Worse?