

Name _____ Age _____ Birthdate ___/___/___ Male/Female

Occupation _____ Today's Date ___/___/___ Right/Left Handed

Who is the doctor, podiatrist or chiropractor requesting this consult?

Name: _____

Address: _____

How did you hear of us? Friend Doctor Internet Yellow Pages Other _____

1. When did your present pain begin?

Are you still working? _____

Last day on the job _____

2. How did the pain start?

Suddenly Gradually Lifting

Twisting Fall Bending

Pulling Work injury

Sports injury No apparent cause

3. What activities make the pain worse?

Exercise Sitting Standing

Walking Coughing Sneezing

Bending forward

Bending backwards

4. What reduces the pain?

Lying down Sitting Standing

Walking Manipulation Physical

Therapy Pain pills Injections

Muscle relaxants

Aspirin or anti-inflammatories

Nothing Other

5. How long have you had this pain or similar pain?

_____ years _____ months _____ weeks

How long have you had similar pain?

_____ years _____ months _____ weeks

5a: **Quality/Severity of pain?** (circle all that apply)

Mild Moderate Severe

Sharp Dull Achy Burning

Pins/needles Numbness

6. Have you had any of these diagnostic studies for your current problem?

	Yes	No	Date
X-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMG	<input type="checkbox"/>	<input type="checkbox"/>	_____
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthrogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
or sonogram			
Injections	<input type="checkbox"/>	<input type="checkbox"/>	

7. What other types of doctors or health care providers have you seen for this condition?

8. Do you have any additional information that would be helpful in understanding your problem?

9. Have you ever been hospitalized or had surgery for this problem? _____

10. Do you take antacids? Yes No

11. Please indicate the last grade you completed in school _____

12. Do you plan to be at your regular job in 6 months?
 Yes No

13. To be sure paperwork is filled out appropriately, please check if appropriate:

- On workman's compensation
- Receiving disability income
- Legal proceeding pending
- Report should be sent to referring physician

Name _____

Address _____

Report should be sent to another party.

CONTINUED →

PAIN PICTURE

Where is your pain now? Mark the areas on your body where you feel the sensations described below using the appropriate symbol. Mark where the pain starts and stops. Include all affected areas for your current problem.

ACHING
△△△

NUMBNESS
====

PINS/NEEDLES
○○○○

BURNING
xxxxx

STABBING
////

FRONT

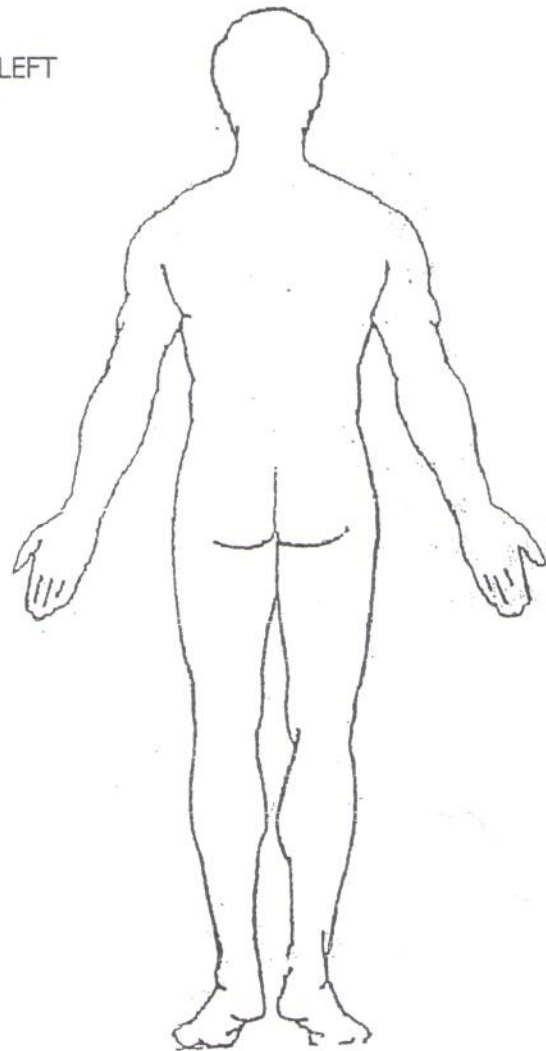
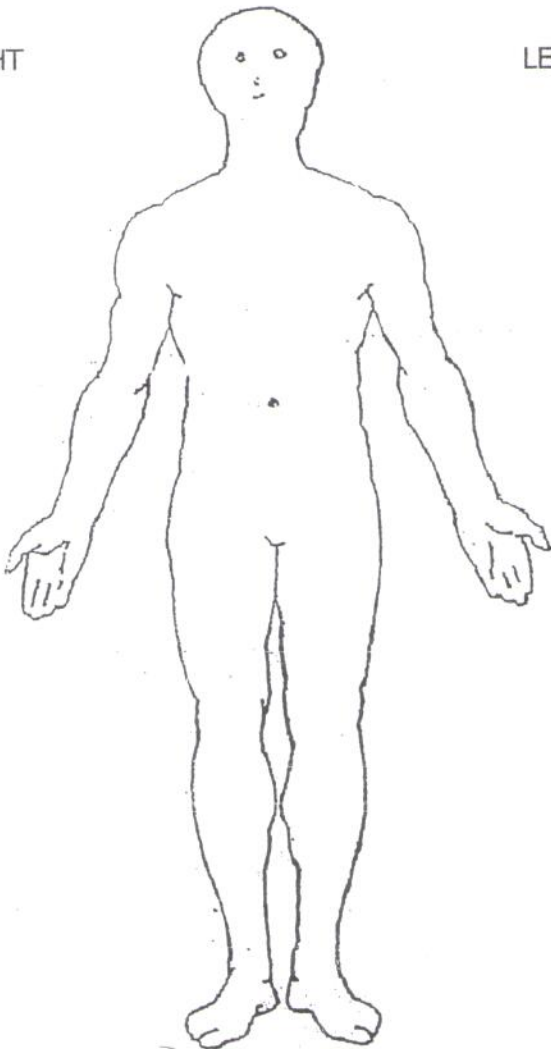
BACK

RIGHT

LEFT

LEFT

RIGHT



Circle a number to show how bad your pain is now on a scale of 0-10, with 10 being the worse pain.

No pain 1 2 3 4 5 6 7 8 9 10 Worse pain

For office use only:

HCC Exam Gait CVS Lymph MS Skin Neuro Xrays Labs Imp: Rec: