Patient Information

Patient Name_____Date_____
Height_____Weight_____Primary Care Physician_____
Are you a smoker? Y N How Long?_____How much?_____/day/week Date stopped:_____
Alcohol use?_____day/week Any unexplained weight loss or gain? Y N _____
Please list all current medications and/or supplements you take: _____
_____
_____

Subjective:

What is your #1 complaint? _____
_____
_____

When did your symptoms begin? _____Describe your symptoms as they began:_____
_____
_____

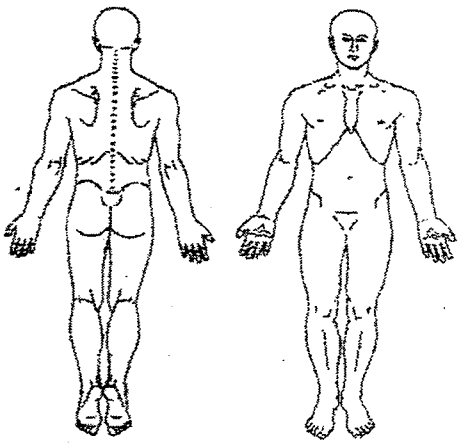
How often do you experience your symptoms?
Please check:
Constantly (76-100% of the day)_____
Frequently (51-75% of the day) _____
Occasionally (26-50% of the day) _____
Intermittently (0-25% of the day) _____

What describes the nature of your symptoms?
Sharp: _____ Shooting: _____
Dull Ache: _____ Burning: _____
Numbness: _____ Tingling: _____

How are your symptoms changing?
Getting better: _____
Not changing _____
Getting worse: _____

Does the pain stay in one place or radiate to:
Arms Y__ /N__ R__/ L__ Legs Y__/N__R__/L__

Draw on the body where you have pain or other symptoms:



Have you noted a change to your bowels or bladder? Y / N _____

Have you used ice or heat to the painful area? Y____/N____ Which? Ice_____ Heat_____

Do the symptoms get worse with Coughing Y___/N___ Sneezing Y___/N___ Straining Y___/N___

		None										Unbearable
How bad are your symptoms at their	A: worst	0	1	2	3	4	5	6	7	8	9	10
	B: best	0	1	2	3	4	5	6	7	8	9	10

How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
No complaints		Mild, forgotten w/activity		Moderate interferes w/activity		Limiting prevents full activity		Intense preoccupied w/ seeking relief		Severe no activity possible