

Name: _____ Date: _____

Home Address: _____

Email Address: _____ Referred by: _____

Phone Numbers (H) _____ (W) _____

SS#: _____ Age: _____ Birth Date: ____/____/____

Type of Injury: () W/C () Auto () Other: _____

Date of Injury/Onset: _____

Employer at time of injury (if W/C): _____

Please describe how you were injured: _____

| | |
|-----------------------|-----|
| STAFF USE ONLY | |
| HT: | |
| WT: | |
| Handed: | R L |
| BP: | |
| PULSE: | |

What treatment have you received since the injury or onset of pain?

() Hospital/Emergency Room: _____

Date(s) of treatment: _____, _____, _____, _____

Medications: _____

Tests/Treatment: _____

() Medical/Surgical Doctor(s): _____

Dates of treatment: From _____ to _____ Type of treatment: _____

Medications: _____

() Chiropractic Doctor(s): _____

Dates of treatment: From _____ to _____ Type of Treatment: _____

() Physical Therapy Location(s): _____

Dates of treatment: From _____ to _____ Type of treatment: _____

What test(s) have you had for this condition?

| TEST | DATE | BODY PART | RESULT |
|------|------|-----------|--------|
| | | | |
| | | | |
| | | | |
| | | | |

What operation(s) have you had for this or any other condition?

| DATE | OPERATION | SURGEON | RESULTS |
|------|-----------|---------|---------|
| | | | |
| | | | |
| | | | |
| | | | |

Current Complaint(s): _____

Have you ever had this problem before? YES NO When? _____

Please explain: _____

What makes your pain better? _____

What makes your pain worse? _____

Do you have trouble holding your bowel or bladder? NO YES Which? _____

Does coughing, sneezing, or straining effect your pain? NO YES How: _____

If yes, where is your pain increased? _____

PAST MEDICAL HISTORY: (P) = Personal; (F) = Family - Please circle all that apply:

| | | |
|--------------------------|-------------------------|-----------------------------|
| Arthritis (P) (F) | Heart Problems (P) (F) | Seizures (P) (F) |
| Asthma (P) (F) | Stroke (P) (F) | Menstrual Problems (P) (F) |
| Bladder problems (P) (F) | Hepatitis (P) (F) | Erection Problems (P) (F) |
| Bowel problems (P) (F) | HIV/AIDS (P) (F) | Weight Gain/Loss (P) (F) |
| Cancer (P) (F) | Kidney Problems (P) (F) | High blood pressure (P) (F) |
| Depression (P) (F) | Osteoporosis (P) (F) | Substance Abuse (P) (F) |
| Diabetes (P) (F) | Ulcers (P) (F) | Other: _____ |

ALLERGIES: _____

DO YOU USE ALCOHOL? YES NO HOW MUCH? _____ HOW OFTEN? _____

DO YOU USE NON-PRESCRIBED DRUGS? YES NO WHAT? _____

DO YOU USE VITAMINS OR HERBAL REMEDIES? YES NO WHAT? _____

DO YOU SMOKE? YES NO _____ Packs/day for _____ years.

DO YOU HAVE ANY IMPLANTED DEVICES? YES NO IF YES, WHERE? _____

ARE YOU PREGNANT? YES NO UNSURE

| Current Medications: | GOOD/BAD EFFECT | Current Medications: | GOOD/BAD EFFECT |
|----------------------|-----------------|----------------------|-----------------|
| 1. _____ | _____ | 4. _____ | _____ |
| 2. _____ | _____ | 5. _____ | _____ |
| 3. _____ | _____ | 6. _____ | _____ |

Current employer: _____ Job: _____

Job Duties: _____

Number of years at this job: _____ Are you currently working?: No Yes

Last day worked: _____ Is there light duty available?: No Yes

How do you like your job? _____

Contact person or case manager: _____ Phone: _____

Last grade of school completed, degree obtained (if any): _____

Do you have a lawyer involved with your injury? Whom? _____

FAMILY/PRIMARY CARE DOCTOR: WHOM SHOULD WE CALL IN CASE OF EMERGENCY?

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

PLEASE RATE THE SEVERITY OF YOUR PAIN RIGHT NOW: Circle a number
(0=NO PAIN / 10=WORST PAIN IMAGINABLE) 0 1 2 3 4 5 6 7 8 9 10

PLEASE RATE THE SEVERITY OF YOUR PAIN ON AVERAGE: Circle a number
(0=NO PAIN / 10=WORST PAIN IMAGINABLE) 0 1 2 3 4 5 6 7 8 9 10

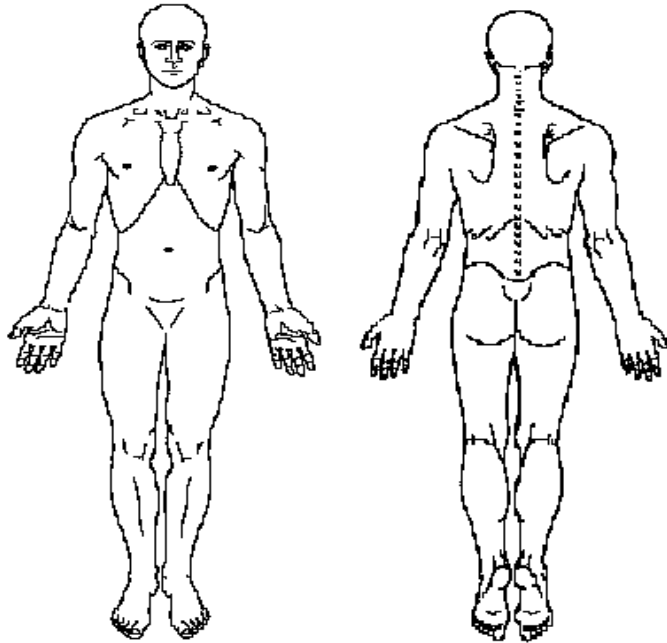
PLEASE RATE THE SEVERITY OF YOUR PAIN AT BEST: Circle a number
(0=NO PAIN / 10=WORST PAIN IMAGINABLE) 0 1 2 3 4 5 6 7 8 9 10

PLEASE RATE THE SEVERITY OF YOUR PAIN AT WORST: Circle a number
(0=NO PAIN / 10=WORST PAIN IMAGINABLE) 0 1 2 3 4 5 6 7 8 9 10

Please indicate where your pain is currently located and what type(s) of pain or sensations you feel at the present time. Use the symbols below to describe your pain.

DO NOT indicate areas of pain, which are not related to your present injury or condition.

- S = Stabbing
- B = Burning
- P = Pins and Needles
- N = Numbness
- A = Aching



Do you have any questions or comments? _____

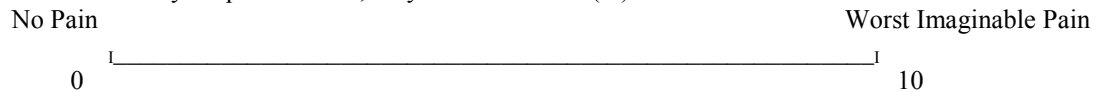
Please describe how your pain/injury has impacted your personal, social and work life: _____

When you have pain (back, leg, neck, arm, etc.) you may find it difficult to do some things you normally do.

This list contains some sentences that people have used to describe themselves when they have pain. When you read them you may find that some stand out because they describe you today. If the sentence describes you **today** then put a check beside it. If the sentence does not describe you then leave it blank. Remember; only check the sentences that describe you today.

- 1. I stay at home most of the time because of my pain
- 2. I change positions frequently to try and get comfortable
- 3. I walk more slowly than usual because of my pain
- 4. Because of my pain, I am not doing any of the jobs that I usually do around the house
- 5. Because of my pain, I lie down to rest more often
- 6. Because of my pain, I use a handrail to get upstairs
- 7. Because of my pain, I have to hold on to something to get out of an easy chair
- 8. Because of my pain, I try to get other people to do things for me
- 9. I get dressed more slowly than usual because of my pain
- 10. I only stand up for short periods of time because of my pain
- 11. Because of my pain, I try not to bend or kneel down
- 12. I find it difficult to get out of a chair because of my pain
- 13. My back, neck, shoulder, hip, knee, foot, etc. is painful almost all of the time
- 14. I find it difficult to turn over in bed because of my pain
- 15. My appetite is not very good because of my pain
- 16. I have trouble putting on my socks or stockings
- 17. I only walk short distances because of my pain
- 18. I sleep less well because of my pain
- 19. Because of my pain, I get dressed with help from someone else
- 20. I sit down for most of the day because of my pain
- 21. I avoid heavy jobs around the house because of my pain
- 22. Because of my pain, I am more irritable and bad tempered with people than usual
- 23. Because of my pain, I go upstairs more slowly than usual
- 24. I stay in bed most of the time because of my pain

How bad is your pain? Please, only draw a vertical (|) line. Do not write a number.



Here are some of the things, which other patients have told us about their pain. For each statement below please circle any number from 0 to 6 to say how you feel about each statement.

| | Completely Disagree | | | Unsure | | | Completely Agree |
|--|------------------------|---|---|--------|---|---|---------------------|
| 1. My pain was caused by physical activity | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. Physical activity makes my pain worse | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. Physical activity might harm my back | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. I should not do any physical activities, which (might) make my back worse | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. I cannot do physical activities that (might) make my back worse | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. My pain was caused by my work or by an accident at work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. My work aggravated my pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. I have a claim for compensation for my pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. My work is too heavy for me | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. My work makes or would make my pain worse | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. My work might harm my back | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. I should not do my normal work with my present pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. I cannot do my normal work with my present pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 14. I cannot do my normal work until my pain is treated | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 15. I do not think that I will be back to my normal work within 3 months | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 16. I do not think that I will ever be able to go back to that work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

In order to better help you, we ask that you take a few minutes to complete these questions. Thank you.
 We will ask that you answer these questions again, in order for us to learn which treatments help patients get better.

1. During the past week, how bothersome have each of the following symptoms been?
 Please circle one number in each row

| | Not bothersome at all | Slightly bothersome | Moderately bothersome | Very Bothersome | Extremely Bothersome |
|-------------------|--------------------------|------------------------|--------------------------|--------------------|-------------------------|
| a. Neck/Back pain | 1 | 2 | 3 | 4 | 5 |
| b. Arm/Leg pain | 1 | 2 | 3 | 4 | 5 |
| c. Head pain | 1 | 2 | 3 | 4 | 5 |

2. During the past week, how much did pain interfere with your normal work, including both work outside the home and housework?

| Not at all | A little bit | Moderately | Quite a bit | Extremely |
|------------|--------------|------------|-------------|-----------|
| 1 | 2 | 3 | 4 | 5 |

3. If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it?

| Very dissatisfied | Somewhat dissatisfied | Neither satisfied nor dissatisfied | Somewhat satisfied | Very satisfied |
|----------------------|--------------------------|---------------------------------------|-----------------------|-------------------|
| 5 | 4 | 3 | 2 | 1 |

4. During the past four weeks, about how many days did you cut down on the things you usually do for more than half of the day because of pain? _____ number of days

5. During the past four weeks, how many days did leg pain keep you from going to work or school? _____ number of days

6. Over the course of treatment for your pain, how satisfied were you with your overall medical care?

| Very dissatisfied | Somewhat dissatisfied | Neither satisfied nor dissatisfied | Somewhat satisfied | Very satisfied |
|----------------------|--------------------------|---------------------------------------|-----------------------|-------------------|
| 5 | 4 | 3 | 2 | 1 |