

# PATIENT INTRODUCTION FORM

Today's Date: \_\_\_\_\_

<b>Last Name:</b>		<b>MI:</b>	<b>First Name:</b>	
<b>Home Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip:</b>
Date Birth:	Age:	Social Security Number:		
Height:	Weight:	Who Referred You to Our Office:		
Employer's Name:		Marital Status (Circle): Single, Married, Divorced, Widowed		
Occupation:		Name of Family Physician:		

<input type="checkbox"/> YES, <input type="checkbox"/> NO I authorize the following telephone numbers <input type="checkbox"/> YES, <input type="checkbox"/> NO I authorize the use of my address for mailing  Home: _____ Work _____  Cell: _____ Pager: _____  Indicate if you have a preferred mailing address: _____  _____  Signature: _____ Date: _____  Expiration Date/Event for Authorization: <input type="checkbox"/> No expiration date <input type="checkbox"/> When I have discontinued treatment and all bills have been paid. <input type="checkbox"/> Date: _____	Our office needs to leave messages, return telephone calls, and send office mail to your home address as part of our normal practice. Federal/State Health Insurance Portability and Accountability Act (HIPAA) patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers that are acceptable for our office to call. Your agreement will allow our office to use your name and the indicated mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. We will use your home address, noted above, unless you indicate a preferred address. You may indicate a preferred mailing address by indicating so on this form. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.
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<b>IS THIS VISIT RELATED TO A:</b>		
<input type="checkbox"/> Work Related Injury/Symptoms	<input type="checkbox"/> Motorcycle-Bicycle Injury	<input type="checkbox"/> Non-Injury Pain/Symptoms
<input type="checkbox"/> Sport or Recreational Injury	<input type="checkbox"/> Home Injury Symptoms	<input type="checkbox"/> Check-up Only
<input type="checkbox"/> Motor Vehicle Crash Injury	<input type="checkbox"/> School/Employment Physical	<input type="checkbox"/> Other (Describe):

## HEALTH-MEDICAL INSURANCE INFORMATION

Does your insurance plan cover Chiropractic treatment?	<input type="checkbox"/> Yes, <input type="checkbox"/> No If yes, we need a copy of the card
If yes, indicate Insurance Company Name (Need copy of card).	Insurance Name: _____ Address: _____ Telephone: _____
Are you the insured person or dependent (wife/husband/child)?	<input type="checkbox"/> Insured, <input type="checkbox"/> Dependent
If you are the insured person's dependent (spouse or child), we need the insured person's name, date of birth, social security number, and the company/business name of the insured employer in order to do billing.	Name of Insured Person: _____ Social Security Number: _____ Insured Date of Birth: _____ Name of Insured Employer: _____
What is your co-payment amount for each visit?	Amount: \$ _____ Percentage: %
Do you have a health insurance deductible for chiropractic?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Deductible \$ _____ Have you met deductible yet?
Specific chiropractic health insurance benefits	Number visits per year # _____. Amount per year: \$ _____

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):  
\_\_\_\_\_

**OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES FOR AS A COURTESY. HOWEVER, IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT AND/OR DEDUCTIBLE FOR REGULAR HEALTH INSURANCE PATIENTS.**

Patient Signature and Date	I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health/automobile insurance carrier. Minors must have parent's signature.
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Form 1000

# GENERAL HEALTH HISTORY

*Check only those conditions that apply to you and indicate if you have had in the past or presently have.*

YES	GENERAL QUESTIONS	PAST	PRESENT
<input type="checkbox"/>	I heal slowly	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Smoke cigarettes or use tobacco products	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes, hypoglycemia, thyroid disorder, kidney or liver disease, or tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart attack or have a heart pacemaker or neck or chest shunt?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Currently or recently had any infectious disease such as AIDS, Tuberculosis, etc	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have problems with dizziness, blacking out, balance, fainting, or tripping	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy-Seizure-Convulsion history or other neurological disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of multiple sclerosis, lupus, psoriasis, temporary paralysis, or meningitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer history or cancer treatment of any type	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have a bulging/herniated disc or disc degeneration in the spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have you ever been hospitalized? Why:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hypertension or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have osteoarthritis, rheumatoid arthritis, or gout of your spine or joints	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Do you have any type of chest or breast implants presently (males &amp; females)?</b>	N/A	<input type="checkbox"/>
<input type="checkbox"/>	<b>Women only:</b> Check box to left if there any chance that you are currently pregnant		

## PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN

**( I have no history of previous painful injury or pain)** If you have had prior injuries or pain, please check below:

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Lifting Injury	<input type="checkbox"/> Car Accident
<input type="checkbox"/> Motorcycle Injury	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Pedestrian Injury	<input type="checkbox"/> Military Injury	<input type="checkbox"/> Other Injury
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> Arm numb-tingling	<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Leg pain- numb-tingling	<input type="checkbox"/> Other Pain:	

## FRACTURES/BROKEN BONES HISTORY

**( I have never had any broken bones).** If you have broken any bones, indicate where and when below:

Region	Year	Region	Year
<input type="checkbox"/> Spinal Vertebra		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar bone (clavicle)		<input type="checkbox"/> Rib bone	
<input type="checkbox"/> Arm or hand bones		<input type="checkbox"/> Leg or foot bones	
<input type="checkbox"/> Pelvis or hip bones		<input type="checkbox"/> Other: List	

## PREVIOUS SURGERIES

**( I have never had any surgical procedure).** If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine Surgery (neck, back, or pelvis)		<input type="checkbox"/> Appendix or stomach	
<input type="checkbox"/> Disc surgery in neck or back		<input type="checkbox"/> Gallbladder/Stomach/Kidney	
<input type="checkbox"/> Heart		<input type="checkbox"/> Cancer (any type)	
<input type="checkbox"/> Head/Brain		<input type="checkbox"/> Hernia (inguinal or hiatal)	
<input type="checkbox"/> Shoulder/Arm/Hip/Leg		<input type="checkbox"/> Other	

## Have you ever been to a Chiropractor before for any condition?

No,  Yes If yes, Chiropractor's Name : \_\_\_\_\_ Year: \_\_\_\_\_  
 Problem(s) seen by Chiropractor for: \_\_\_\_\_

Form 1010

# GENERAL HEALTH HISTORY (Page 2)

## LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
<input type="checkbox"/> Headaches/Migraines		<input type="checkbox"/> Upper Back Pain, Soreness, or Stiffness	
<input type="checkbox"/> Neck Pain, Soreness, or Stiffness		<input type="checkbox"/> Hip Pain	
<input type="checkbox"/> Low Back Pain, Soreness, Stiffness		<input type="checkbox"/> Leg or Foot Pain, Numbness, or Tingling	
<input type="checkbox"/> Arm/Hand Pain, Numbness, or Tingling		<input type="checkbox"/> Other:	

**Did your current symptoms come on?**  Suddenly,  Gradually

### SYMPTOM/PAIN DESCRIPTION

*Please circle any word or all words below that best describes how your symptoms currently feel to you.*

Pain	Pinching	Spreading	Vicious	Unbearable
Ache	Pricking	Shooting	Sickening	Soreness
Cutting	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep pain	Falls asleep
Irritating	Burning-Hot	Dreadful	Superficial pain	Suffocating
Annoying	Drill like	Fearful	Stinging	Punishing
Stiff or tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

No,  Yes Do you have any problems laying face down on an examination table? If yes, why: \_\_\_\_\_

### ARE YOU TAKING ANY MEDICATIONS?

**I am not taking any medications currently.** Check any of the following that you are taking currently.

<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Blood pressure/Stroke prevention medications	<input type="checkbox"/> Cortisone injections
<input type="checkbox"/> Pain/Anti-inflammatory meds	<input type="checkbox"/> Osteoporosis (bone strengthening) medications	<input type="checkbox"/> Other:

### WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?

<input type="checkbox"/> Morning is when pain is worse	<input type="checkbox"/> Bending your back increases pain	<input type="checkbox"/> Walking increases pain
<input type="checkbox"/> Afternoon/evening pain worse	<input type="checkbox"/> Lying down flat increases pain	<input type="checkbox"/> Standing increases pain
<input type="checkbox"/> During sleep hours pain worse	<input type="checkbox"/> Sitting increases pain	<input type="checkbox"/> Exercise/Stretching increases pain
<input type="checkbox"/> Standing up from sitting	<input type="checkbox"/> Poor posture increases pain	<input type="checkbox"/> Other:

### WHAT ACTIVITIES LESSEN YOUR PAIN?

<input type="checkbox"/> Walking	<input type="checkbox"/> Being flat on your back	<input type="checkbox"/> Exercise/Stretching
<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Other:

### DO YOU EXERCISE?

<input type="checkbox"/> I do no regular exercise	<input type="checkbox"/> I exercise 1-2 times a week	<input type="checkbox"/> I exercise 3-5 times a week
<input type="checkbox"/> I stretch regularly	<input type="checkbox"/> I do weight lifting at gym/home	<input type="checkbox"/> I do cardiovascular work outs
<input type="checkbox"/> I am willing to do exercise	<input type="checkbox"/> I am not willing to do exercises	<input type="checkbox"/> I do regular sports activities

### HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

<input type="checkbox"/> Excessive fatigue-malaise	<input type="checkbox"/> Bowel or bladder disorders	<input type="checkbox"/> Night pain or night time sweats
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Ovarian pain	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Kidney pain/painful urination	<input type="checkbox"/> Balance problems

Form 1010

# HEADACHE-MIGRAINE QUESTIONNAIRE

Please answer the following sections that apply to you. If some of the questions are unclear to you, skip ahead to the next question. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.

**1. If your headaches/migraines have begun recently, can you think of some event or cause that may have started your pain?**  YES,  NO If yes, what: \_\_\_\_\_

**2. If your headaches/migraines have been bothering you for more than 6 months, can you describe what you think is causing them or making them worse?**  
 YES,  NO If yes, describe: \_\_\_\_\_

**3. Circle how intense your typical headaches/migraines are recently? (Use 0-10 intensity)**

Pain Intensity	None	Mild Discomfort/Annoyance	Moderate Hurts/Sore/Bearable Sensation	Severe Sharp/Intense/Unbearable
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Headache (circle)	0	1	2	3	4	5	6	7	8	9	10
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**4. Recently have your headaches-migraines been?**

The same,  Better,  Worse,  Unusually intense,  Unusual type or unusual location of headache

**5. WHEN DO YOU USUALLY GET YOUR HEADACHES-MIGRAINES?**

<input type="checkbox"/> Morning *	<input type="checkbox"/> End of week	<input type="checkbox"/> After napping or oversleeping
<input type="checkbox"/> Afternoon	<input type="checkbox"/> Bright light causes them	<input type="checkbox"/> After drinking alcohol
<input type="checkbox"/> Evening	<input type="checkbox"/> During or after having sex	<input type="checkbox"/> Before menstrual cycle
<input type="checkbox"/> During sleep	<input type="checkbox"/> During emotional stress	<input type="checkbox"/> During menstrual cycle
<input type="checkbox"/> During weekends *	<input type="checkbox"/> After emotional stress	<input type="checkbox"/> After menstrual cycle
<input type="checkbox"/> Beginning of week	<input type="checkbox"/> During physical exertion	<input type="checkbox"/> After bending your head downwards
<input type="checkbox"/> Middle of week	<input type="checkbox"/> After not eating several hours	<input type="checkbox"/> No pattern

**6. WHAT USUALLY HELPS YOUR HEADACHES-MIGRAINES?**

<input type="checkbox"/> Sleeping	<input type="checkbox"/> Improving posture	<input type="checkbox"/> Drinking coffee
<input type="checkbox"/> Rest	<input type="checkbox"/> Dark quiet room	<input type="checkbox"/> Muscle massage
<input type="checkbox"/> Eating	<input type="checkbox"/> Medications	<input type="checkbox"/> Cold packs
<input type="checkbox"/> Spinal adjustments	<input type="checkbox"/> Nothing helps	<input type="checkbox"/> Other:

**7. DESCRIBE HOW YOUR HEADACHE-MIGRAINE USUALLY FEELS:**

<input type="checkbox"/> Pounding	<input type="checkbox"/> Burning	<input type="checkbox"/> Pressure
<input type="checkbox"/> Constant pain	<input type="checkbox"/> Aching	<input type="checkbox"/> Exploding
<input type="checkbox"/> Throbbing *	<input type="checkbox"/> Sharp-Piercing	<input type="checkbox"/> Dullness

**8. Where does most of your headache pain focus or concentrate?** (Check all that apply)

<input type="checkbox"/> Entire head area	<input type="checkbox"/> Front of head	<input type="checkbox"/> Left side of head
<input type="checkbox"/> Back of head near neck area	<input type="checkbox"/> Eye region	<input type="checkbox"/> Right side of head
<input type="checkbox"/> Top of head	<input type="checkbox"/> No pattern	<input type="checkbox"/> Both sides of head

**9. If your head pain radiates, where do your headaches-migraines start?**

<input type="checkbox"/> Neck area	<input type="checkbox"/> Front of head	<input type="checkbox"/> Near eyes
<input type="checkbox"/> Back of head	<input type="checkbox"/> Side of head	<input type="checkbox"/> Other:

\*See answers to common diagnosis questions.

# HEADACHE-MIGRAINE FORM (Page 2)

Recently, how many headaches/migraines do you usually have in a month? \_\_\_\_\_ Times a month  
 Recently, how many hours does a typical headache/migraine last for you? \_\_\_\_\_ Hours  
 On average, how many pills do you take every month for headaches? \_\_\_\_\_ Number pills per month

**10.**  YES,  NO Have you seen other Doctors for your headaches-migraines? Please list and describe treatment and if it helped. Also indicate if you have had any brain scans, laboratory tests, or other diagnostic tests done to evaluate your headaches. \_\_\_\_\_

What have your previous doctors told you were the cause(s) for your headaches?

## 11. MEDICATIONS:

*Check all medications that you have taken recently for any condition. Please write in names of all medications:*

<input type="checkbox"/> Prescription pain medications	<input type="checkbox"/> Anti-inflammatory medications
<input type="checkbox"/> Muscle relaxants	<input type="checkbox"/> Over-the-counter pain medications
<input type="checkbox"/> Asthma drugs	<input type="checkbox"/> Estrogen or oral contraceptives
<input type="checkbox"/> Heart or blood pressure medications	<input type="checkbox"/> Other:

## 12. HEADACHE-MIGRAINE HISTORY (Check any of the following that apply to you):

<input type="checkbox"/> Family history of headaches or migraines
<input type="checkbox"/> History of motion sickness as a child
<input type="checkbox"/> Headaches-migraines associated with shortness of breath or excessive exhaustion *
<input type="checkbox"/> Headaches-migraines associated with numbness of face and/or tongue
<input type="checkbox"/> Headaches-migraines associated with arm or leg weakness
<input type="checkbox"/> You usually know your headache is starting soon by various symptoms such as visual or sensory feelings
<input type="checkbox"/> You see lights/spots in your vision 5-50 minutes before headache-migraine pain begins
<input type="checkbox"/> You are very sensitive to light or sound during or after headache-migraine
<input type="checkbox"/> You presently or recently had a fever. This fever began just before your headaches started or during headache.
<input type="checkbox"/> You had a rash, chills, fever, headache, and joint pain/swelling 2 weeks prior to your headaches starting.*
<input type="checkbox"/> Physical exertion makes your headache-migraine worse (climbing stairs, sex, lifting, etc)
<input type="checkbox"/> Headaches start 3-4 hours after eating and/or your headaches improve after you eat *
<input type="checkbox"/> Jaw pain before or during headache
<input type="checkbox"/> Muscles in neck and shoulders are tight/stiff or sore prior to headache
<input type="checkbox"/> Headaches-migraines get worse when you have sustained poor posture
<input type="checkbox"/> Headaches-migraines begin or get worse when you rotate or twist your head and/or neck
<input type="checkbox"/> You get dizzy or black out when headaches-migraines occur
<input type="checkbox"/> Get tearing, face flushing, or nasal discharge during headache-migraine
<input type="checkbox"/> History of sinus infection, allergies, deviated septum, or other nasal disorders
<input type="checkbox"/> You bruise easily, sometimes finding bruises on your thighs or legs and you can't recall any injury to your leg.*
<input type="checkbox"/> History of neck or head injury
<input type="checkbox"/> You eat or drink substances having caffeine (coffee, chocolate, or tea). I drink _____ number of cups per day.
<input type="checkbox"/> Your body usually feels cold *
<input type="checkbox"/> Thyroid problems currently or in past
<input type="checkbox"/> You do not feel rested after sleeping

\* See commonly asked questions.

## SYMPTOM QUESTIONNAIRE (Page 2)

Please answer the following sections that apply to you. If some of the questions are unclear to you, skip ahead to the next question. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.

### NECK REGION

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Does neck and head movement cause your neck pain to intensify?
<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy when you look up or twist your head? If yes, how often:
<input type="checkbox"/>	<input type="checkbox"/>	Do you black out or lose your balance when you look up or twist your head? If yes, how often:
<input type="checkbox"/>	<input type="checkbox"/>	Do you have to support your head with your hand or grasp your mouth or hair to be able to lift your head up when you are lying down and attempting to sit up? If your difficulty/inability to lift your head without support is injury related, indicate how soon this occurred after injury? ( _____ min/hrs)
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel your neck pain sends pain downwards between your shoulders?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel your neck pain sending pain downwards to the front of your chest?
<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed your head leaning or tilting to one side recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed as having a disc bulge or disc herniation in your neck?

### ARM, HAND, OR FINGER REGION

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain, numbness, or tingling in your shoulder, elbow, forearm, or hand? Circle areas
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain, numbness, or tingling in your fingers? If Yes, circle finger(s) that are involved: Thumb, Index finger, Middle finger, Ring finger, Little finger
<input type="checkbox"/>	<input type="checkbox"/>	Do you get increased arm numbness when lying flat on your back* or sleeping on your side?*
<input type="checkbox"/>	<input type="checkbox"/>	Does changing your sitting posture increase your arm/hand symptom intensity?
<input type="checkbox"/>	<input type="checkbox"/>	If you sit and slouch forward for several minutes, do your arm symptoms intensify?
<input type="checkbox"/>	<input type="checkbox"/>	If you have arm symptoms, do they improve when you lift your arms over your head? *
<input type="checkbox"/>	<input type="checkbox"/>	If you have arm symptoms, do they worsen when you lift your arms over your head? *
<input type="checkbox"/>	<input type="checkbox"/>	If you have hand or arm pain at night, does it help to shake and massage them?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hands feel tender when you grasp objects?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel weakness in your grip strength?
<input type="checkbox"/>	<input type="checkbox"/>	Do you drop objects from your hand?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficulty writing or doing small motions with your fingers recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hand(s) or wrist swell?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hands burn?
<input type="checkbox"/>	<input type="checkbox"/>	Are your fingers or hands frequently cold?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed as having Carpal Tunnel Syndrome or Raynaud's syndrome in your past?

\* See commonly asked questions.

### MIDDLE BACK AND CHEST WALL REGION

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain that shoots or radiates outward along your rib cage?
<input type="checkbox"/>	<input type="checkbox"/>	Does your middle back or chest wall pain intensify when you take in a deep breath or cough?
<input type="checkbox"/>	<input type="checkbox"/>	Does your middle back or chest wall pain intensify when you twist your torso, bend, or stoop forward?
<input type="checkbox"/>	<input type="checkbox"/>	When you move your neck around, does your middle back pain or chest pain increase?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed as having angina before?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a tight band-like feeling sometimes around your chest?
<input type="checkbox"/>	<input type="checkbox"/>	Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
<input type="checkbox"/>	<input type="checkbox"/>	Does your middle back pain mostly bother you during sleep?

Form 1030

# SYMPTOM QUESTIONNAIRE (Page 3)

## LOW BACK, HIP AND LEG/FOOT REGION

**Check any of the following that intensify your low back pain and/or leg symptoms:**

<input type="checkbox"/> Sitting	<input type="checkbox"/> Bending forward	<input type="checkbox"/> Standing up	<input type="checkbox"/> Walking
<input type="checkbox"/> Standing still	<input type="checkbox"/> Bending backward	<input type="checkbox"/> Lying on your back	<input type="checkbox"/> Putting on shoes

**Check any of the following that lessen/improve your low back pain and/or leg symptoms:**

<input type="checkbox"/> Sitting	<input type="checkbox"/> Bending forwards	<input type="checkbox"/> Standing up	<input type="checkbox"/> Walking
<input type="checkbox"/> Standing still	<input type="checkbox"/> Bending backwards	<input type="checkbox"/> Lying on your back	<input type="checkbox"/> Putting on shoes

**Check all locations of any current leg pain, numbness, or tingling:**

<input type="checkbox"/> Hip	<input type="checkbox"/> Buttock	<input type="checkbox"/> Back of thigh	<input type="checkbox"/> Calf
<input type="checkbox"/> Groin area	<input type="checkbox"/> Knee	<input type="checkbox"/> Front of thigh	<input type="checkbox"/> Foot/toes

**YES NO** *Check all areas with a yes or no (Skip if you are unclear about question)*

<input type="checkbox"/>	<input type="checkbox"/>	When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get worse?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distances that is relieved by resting or sitting down? This pain resumes after walking for same distance. *
<input type="checkbox"/>	<input type="checkbox"/>	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at night or while sitting. *
<input type="checkbox"/>	<input type="checkbox"/>	Does either leg or foot drag on the floor when you walk?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a lot of leg cramps at night recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you recently had any urinary or bowel incontinence or had difficulty urinating?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had abdominal pain, indigestion, colicky symptoms with your low back pain?
<input type="checkbox"/>	<input type="checkbox"/>	Have you observed that your low back pain is not relieved or made worse by any type of postural change?
<input type="checkbox"/>	<input type="checkbox"/>	Do your feet feel cold recently? If yes, indicate which foot or if both feet:
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed as having a herniated or bulging disc in your low back in the past?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an injection of Chymopapain into your discs (Spine) in your back or neck?
<input type="checkbox"/>	<input type="checkbox"/>	Have you recently noticed that either of your legs occasionally gives out on you when you walk? *
<input type="checkbox"/>	<input type="checkbox"/>	Does one or both of your legs feel weak recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed as having a spondylolisthesis in your low back region?
<input type="checkbox"/>	<input type="checkbox"/>	Have you or either of your parents ever been diagnosed as having an abdominal aneurysm?
<input type="checkbox"/>	<input type="checkbox"/>	If you have radiating leg or foot pain did you notice your leg symptoms before the low back pain started?
<input type="checkbox"/>	<input type="checkbox"/>	If you have leg pain, is your pain primarily focused in front of your thigh(s)?*
<input type="checkbox"/>	<input type="checkbox"/>	Has your anal-rectal region been completely numb?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any recent prostate, ovarian, or uterine problems?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had abdominal surgery, chest surgery, reconstructive surgery or other conditions in your past where your doctor has recommended that you should be careful when twisting or lifting?
<input type="checkbox"/>	<input type="checkbox"/>	Other:

\* See commonly asked questions

## SLEEPING PATTERNS

**YES NO**

<input type="checkbox"/>	<input type="checkbox"/>	Do you sleep poorly at night?
<input type="checkbox"/>	<input type="checkbox"/>	Do you sleep on your stomach?
<input type="checkbox"/>	<input type="checkbox"/>	Do you consistently feel extremely tired when you wake up in the morning?

Form 1040