# INITIAL VISIT INFORMATION

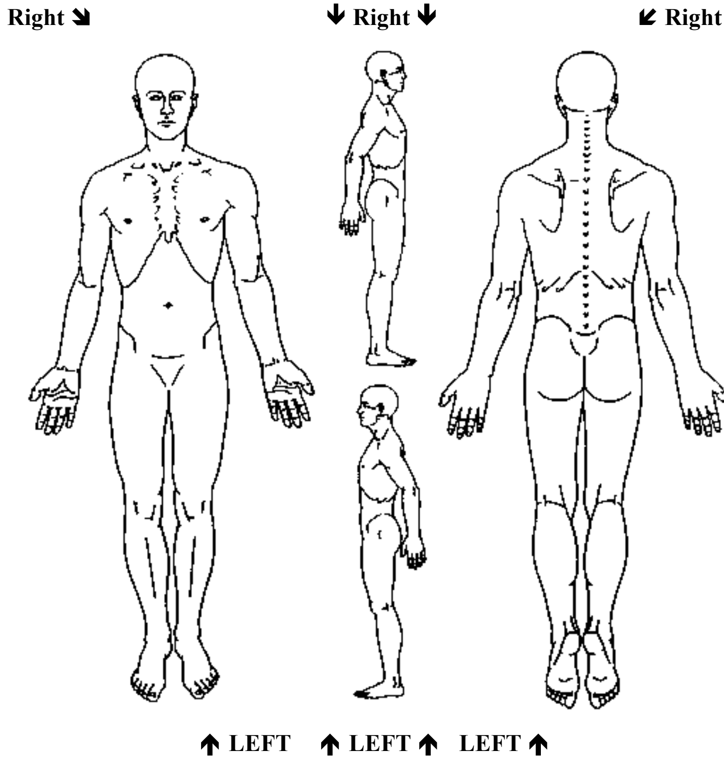
**DATE** ___/___/___

Your Name: ______________________________

Referred By: ______________________________

Age: ______ YRS    Sex (Circle) : M F

**WHERE is your pain located?** Using these pictures, shade with a pen or pencil the parts of your body that are affected by pain.




**When / How long ago did your pain start?**

_____ Years    _____ Month(s)

_____ Week(s)    _____ Day(s)

Any Specific Date? _____ /______ / ______

**How did your pain start?**

- ❑ Traffic Accident
- ❑ Unknown
- ❑ Work Injury

**How often do you have your pain?** (Please check one)

- ❑ Constantly (80-100% of time)
- ❑ Frequently (50-80% of the time)
- ❑ Intermittently (25-50% of the time)
- ❑ Occasionally (less than 25% of the time)

**How would you grade AVERAGE DAILY intensity of your pain?** (PLEASE CIRCLE)
(Zero = "no pain", 10 = "worst pain imaginable")

0 1 2 3 4 5 6 7 8 9 10

**How do the following affect your pain?**
(Please check the ones applicable to your condition)

| | Increases Pain | Reduces Pain |
|---|---|---|
| Standing | ❑ | ❑ |
| Sitting | ❑ | ❑ |
| Lying Down | ❑ | ❑ |
| Walking | ❑ | ❑ |
| Exercise | ❑ | ❑ |
| Coughing or Sneezing | ❑ | ❑ |
| Passing Urine/ Bowels | ❑ | ❑ |

**Check additional symptoms you are experiencing with their location**

- ❑ Tingling (pins-needles): ____________________
- ❑ Numbness: ____________________
- ❑ Cold / Hot skin: ____________________
- ❑ Cramps: ____________________
- ❑ Imbalance / Repeated Falls
- ❑ Weakness: ____________________
- ❑ Pain EVEN with bed-rest
- ❑ Chills / Night Sweats / Fever
- ❑ Uncontrolled loss of urine or bowels
- ❑ Weight loss (10-15 pounds in 2 weeks or less)

**Check the treatments you have tried for your pain and complete the appropriate column on the right**

- ❑ Physical Therapy for _______ Week(s)
- ❑ Name of Physical Therapy Center ____________________
- ❑ Chiropractor (name) ____________________
- ❑ Currently seeing your chiropractor YES NO
- ❑ Heat / Ice / Traction / TENS / Acupuncture (circle)
- ❑ Medications you have tried for the current pain: ____________________
- ❑ Injections (if any) done for the current pain: ____________________
- ❑ Surgery/surgeries done to address current pain: ____________________

**Please review the list of symptoms below. Please check the box ❑ next to the ones you suffer from:**

- ❑ Weight gain
- ❑ Headache
- ❑ Seizures
- ❑ Fainting
- ❑ Memory loss
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Cough
- ❑ Tremors
- ❑ Anxiety
- ❑ Depression
- ❑ Hallucinations
- ❑ Suicidal thoughts
- ❑ Suicide attempts
- ❑ Poor appetite
- ❑ Constipation
- ❑ Chest pain
- ❑ Palpitations
- ❑ Swelling in legs
- ❑ Passing stones in urine
- ❑ Erectile dysfunction
- ❑ Abnormal vaginal bleed
- ❑ Painful muscles
- ❑ Painful /swollen joints
- ❑ Difficulty in hearing
- ❑ Easy bruising / bleeding
- ❑ Loud snoring
- ❑ Daytime tiredness

## LIST YOUR MEDICAL HISTORY:

- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Hypothyroidism
- ❑ Heart Disease
- ❑ GERD
- ❑ Diabetes
- ❑ Anxiety
- ❑ Depression
- ❑ Asthma
- ❑ COPD / Emphysema
- ❑ Sleep Apnea
- ❑ Kidney Disease

**Use following space to list any other medical conditions:**

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

## DOCUMENT ANY SURGICAL PROCEDURES THAT YOU EVER HAD (if possible, provide year):

- ❑ Tonsillectomy
- ❑ Appendectomy
- ❑ Breast Surgery
- ❑ Gall bladder removal
- ❑ Thyroid Removal
- ❑ Hysterectomy

**Use following space to list other surgeries you had:**

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

## ALLERGIES: ❑ I HAVE NO ALLERGIES

- ❑ Penicillin
- ❑ Sulfa
- ❑ MRI Dye
- ❑ CT Dye
- ❑ Iodine
- ❑ Shellfish

____________________ ____________________
____________________ ____________________

## LIST ALL MEDICATIONS YOU ARE TAKING

Include "over the counter" drugs and herbal supplements.

________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

## ARE ANY OF YOUR FAMILY MEMBERS SUFFERING FROM THE FOLLOWING?

| Select all that apply: | Relationship to you: |
|---|---|
| ❑ Cancer | ____________________ |
| ❑ Diabetes | ____________________ |
| ❑ Kidney Disease | ____________________ |
| ❑ Chronic Pain | ____________________ |
| ❑ Alcohol Abuse | ____________________ |
| ❑ Illegal Drug Abuse | ____________________ |
| ❑ Prescription Drug Abuse | ____________________ |

## PERSONAL HISTORY

Are you currently working? YES NO

What is your occupation? ____________________

Are you on disability? YES NO

Reason for your disability? ____________________

Do you have any pending litigation related to your current pain issue? YES NO

Do you live alone? YES NO

Do you use tobacco? YES NO

Number of cigarettes use per day: ____________________

How long have you been smoking? ____________________

Do you use alcohol? YES NO

How often do you use alcohol: ____________________

Have you ever been treated for alcohol related problems? YES NO

Have you ever used any street drugs? YES NO

Have you ever been dependent on or treated for prescription drug abuse? YES NO