

Date: _____
 Name: _____
 Occupation: _____

DOB (yyyy-mm-dd): _____
 If retired, past occupation: _____

Are you latex sensitive? Yes No

Do you smoke? Yes No

FOR WOMEN: Are you or could you be pregnant? Yes No

Do you have a pacemaker? Yes No

Have you recently noted any of the following? (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Numbness/tingling: where? _____ | <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Changes in appetite |
| <input type="checkbox"/> Muscle weakness: where? _____ | <input type="checkbox"/> Double vision | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Unexplainable weight loss 10+ lbs last 3 mth | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Fever/Chills |
| <input type="checkbox"/> Pain with coughing or sneezing | <input type="checkbox"/> Fainting | <input type="checkbox"/> Falls |
| <input type="checkbox"/> Changes in bowel or bladder function | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Other: _____ | | |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Recent bacterial infection | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Upper respiratory tract infection | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hemophilia or other bleeding conditions | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Kidney/Liver disease | <input type="checkbox"/> Heart Disease/Angina | <input type="checkbox"/> Bone infection |
| <input type="checkbox"/> Osteoarthritis/Osteoporosis | <input type="checkbox"/> Chemical dependency (i.e., alcoholism) | |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Other: _____ | |

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches): If you have a pre-made list, simply let our front desk coordinator scan this document to save you time. _____

Have you ever taken STEROID medications? Yes No If yes, for how long? _____

Have you recently taken OR currently taking blood thinning medications? Yes No

What are you coming in for today? _____

When did your symptoms start? _____

Have you ever had this problem before? Yes No If yes, when? _____

Previous treatment received? _____

Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survey: ____/10

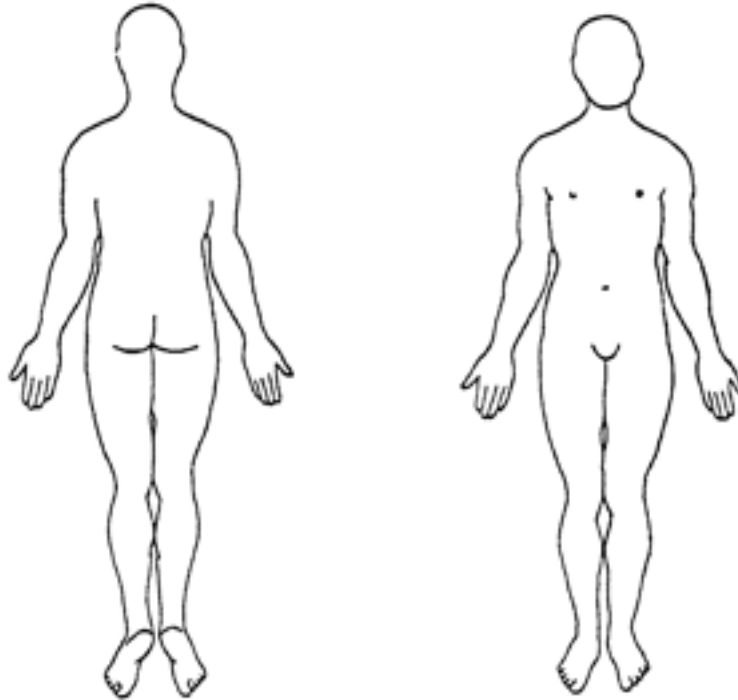
Your pain during the past 24 hours has been at its **BEST:** ____/10, and at its **WORST** ____/10

Do you consent to treatment today? Yes No Signature: _____

Patients Name: _____

Date: _____

Body Chart:



Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night in regards to your symptoms?

- No problem sleeping Difficulty falling asleep
 Awakened by pain Sleep only with medication

What position do you sleep in? Back Front RT Side LT Side

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms best? Morning Afternoon Evening Night After exercise