

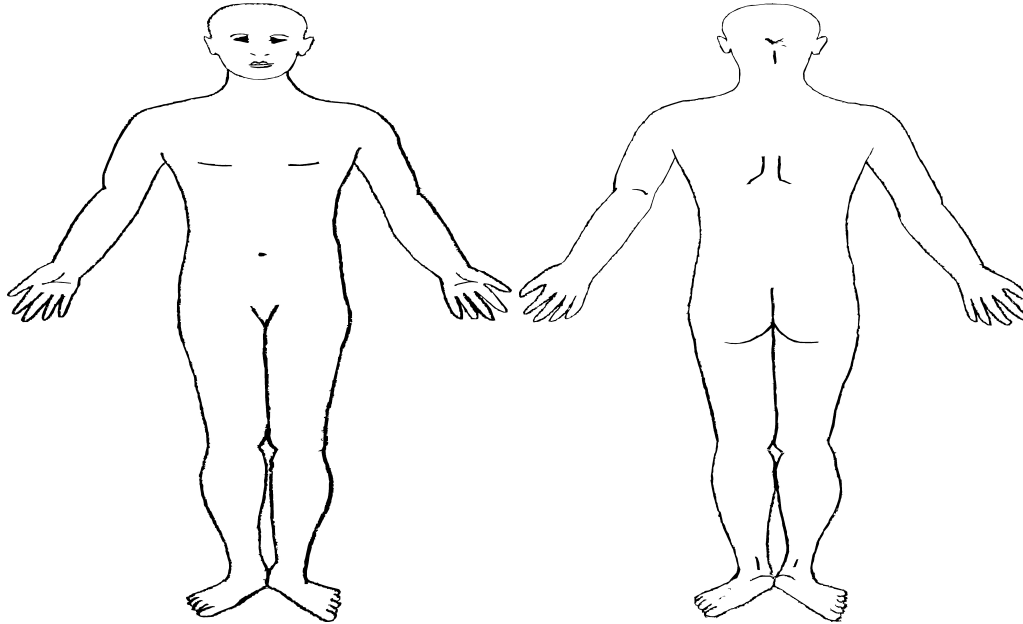
Current Chief Complaint

Using the symbols shown, please indicate where you are having your problem or problems:

... Pain

X Numbness

|| Weakness



1. The majority of my pain is in my:

(check **ONE** only)

- head
- neck
- arm
- back
- leg

2. My pain has been present for :

(check **ONE** only)

- < 1 month
- 1-3 months
- 3-6 months
- > 6 months

3. My pain is: (check one only):

- getting better
- getting worse
- staying the same

4. My problem is: (check **ONE** only):

- present all the time
- comes and goes

5. Briefly describe how your problem began:

6. What makes your pain worse?

7. What relieves your pain?

8. I have tried the following treatments and they have:

		Helped a lot	Helped a little	No help at all	Made worse
<input type="checkbox"/>	Medication				
<input type="checkbox"/>	Physiotherapy				
<input type="checkbox"/>	Chiropractic				
<input type="checkbox"/>	Acupuncture				
<input type="checkbox"/>	IMS				
<input type="checkbox"/>	Spinal Injections				
<input type="checkbox"/>	Other (Describe)				

9. Please list any health care providers you are currently seeing:

Physiotherapist:	
Chiropractor:	
Massage Therapist:	
Personal Trainer:	
Other (Please describe):	

10. Anything else you would like to add that has not already been covered?

Past Medical History

1. Comorbidities

Have you ever had or do you currently have any of the following conditions?

	YES	NO
AIDS		
Alzheimer's disease or another form of dementia		
Asthma		
Blood clots in your legs		
Cancer (not including skin cancer, leukemia, or lymphoma)		
Cirrhosis or serious liver damage		
Diabetes (high blood sugar)		
Emphysema, chronic bronchitis, or chronic obstructive lung disease		
Fibromyalgia		
Heart attack		
Heart failure		
Hypertension (high blood pressure)		
Kidney problems		
Leukemia or polycythemia vera		
Lupus (Systemic lupus erythematosus)		
Lymphoma		
Osteoporosis		
Polymyalgia rheumatica		
Rheumatoid arthritis		
Stomach ulcers or peptic ulcer disease		
Stroke, cerebrovascular accident, or transient ischemic attack (TIA)		

2. Surgical History

Indicate what operations you have had in the past (Check all that apply - please give year and reason)

	Surgery	Year	Reason
<input type="checkbox"/>	brain		
<input type="checkbox"/>	ears		
<input type="checkbox"/>	nose		
<input type="checkbox"/>	throat (include tonsils)		
<input type="checkbox"/>	Spine (neck or back)		
<input type="checkbox"/>	lungs		
<input type="checkbox"/>	heart		
<input type="checkbox"/>	breast		
<input type="checkbox"/>	liver		
<input type="checkbox"/>	appendix		
<input type="checkbox"/>	gall bladder		
<input type="checkbox"/>	pancreas		
<input type="checkbox"/>	kidneys		
<input type="checkbox"/>	small bowel		
<input type="checkbox"/>	large bowel (colon)		



	Surgery	Year	Reason
<input type="checkbox"/>	uterus		
<input type="checkbox"/>	ovaries		
<input type="checkbox"/>	knee		
<input type="checkbox"/>	hip		
<input type="checkbox"/>	shoulder		
<input type="checkbox"/>	other		

3. Medications

Please list the names of the medications you take, the doses, and the frequency

Name	Dose	Frequency

4. Allergies

Please list any sensitivities or allergies you suffer from and the effect they have on you

Agent	Effect
(e.g.) erythromycin	upset stomach

5. Smoking History

(Check **One** only)

- I have never smoked
- I quit smoking more than 10 years ago
- I quit smoking more than 5 years ago
- I quit smoking more than 1 year ago
- I quit smoking more than 3 months ago
- I have quit smoking in the last 3 months
- I smoke 1/2 pack or less per day
- I smoke 1/2-1 pack per day
- I smoke more than 1 pack per day

6. Alcohol Consumption

(Check **One** only)

- I do not drink alcohol
- I have 1 or 2 drinks per year
- I have 1 or 2 drinks per month
- I have 1 or 2 drinks per week
- I have 5 or 6 drinks per week
- I have 1 or 2 drinks per day
- I have more than 2 drinks per day