History

When did condition(s) begin and how? _____

_____

_____

List your current condition(s) or symptom(s) in the order of decreasing severity:

1. _____

   Duration: _____ Frequency: _____

2. _____

   Duration: _____ Frequency: _____

3. _____

   Duration: _____ Frequency: _____

4. _____

   Duration: _____ Frequency: _____

5. _____

   Duration: _____ Frequency: _____

6. _____

   Duration: _____ Frequency: _____

7. _____

   Duration: _____ Frequency: _____

8. _____

   Duration: _____ Frequency: _____

PRIOR MEDICAL CARE:

Please list all surgeries and approximate dates:

Date	Type of Surgery	Post-operative complication(s)

Of the following diagnostic procedures, please indicate those you have undergone:

Study	No	Yes	Date	Results
Reg. Spine x-rays				
MRI				
CT Scan				
Bone Scan				
EMG				
Nerve Block				
Other: _____	N/A			

History of fractures:

Date	Fracture	Complications

LIFESTYLE HISTORY:

Do you (or have you) ever smoked cigarettes, cigars, a pipe, or used chewing tobacco? Yes / No

If yes, how many years? _____ If yes, what is the frequency during an average day? _____

If yes, what age were you when you quit? _____ ☐ N/A because I have not quit.

Do you drink alcoholic beverages? Yes / No

If yes, for how many years? _____ If yes, average number of drinks per week: _____

Have you ever used alcohol to control your pain? Yes / No

HISTORY OF PREVIOUS CONDITION(S):

Prior to this current condition(s), have you ever had similar condition that required professional help? Yes / No

If yes, briefly explain: _____

Other than this current condition, have you ever had any previous neck or back symptoms, that required professional help? Yes / No

If yes, briefly explain: _____

(continued on next page)

OCCUPATIONAL HISTORY:

How physically demanding is your job?

- ☐ Very heavy (frequently lifting 100 or more pounds
- ☐ Heavy (frequently lifting 60 – 100 pounds)
- ☐ Moderate (frequently lifting 30 – 60 pounds)
- ☐ Light (frequently lifting 10 – 30 pounds)
- ☐ Sedentary (essentially no lifting)

Your work status at time of onset of this condition(s)

- ☐ Regular duties (full time)
- ☐ Temporary light duties
- ☐ Permanent light duties
- ☐ Not currently in work force
- ☐ On disability or time loss
- ☐ On public assistance

How satisfied are you with your job?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ It is the worst job I have had

When was the last time you worked?

- ☐ Today
- ☐ Yesterday
- ☐ Last week
- ☐ Last month
- ☐ Last year

Other: _____

Has your employer treated you fairly? Yes / No

FEMALES ONLY:

Indicate all that apply:

- ☐ Vaginal bleeding other than time of menstrual cycle
- ☐ Obstetrician/gynecological exam within the last two years.
- ☐ Currently having painful menstrual cycles that interfere with daily life
- ☐ Back pain increases with menstrual cycles.
- ☐ I have other menstrual problems
- ☐ I may be or I am currently pregnant. Approximate due date: _____

Signature: _____

(Please sign whether pregnant or not)