NAME:_____ **DATE:** _____

BIRTHDATE:_____ **AGE:**_____ **HEIGHT:**____**ft.** ____**in.** **WEIGHT:**_____ **lbs.**

Referring doctor's name & address: _____

_____

Internist or family doctor's name & address: _____ Same as above

_____

A. Chief Complaint

1. What is your MAIN reason for seeing the doctor? (Check all that apply)

___Neck pain Arm, shoulder, or hand: ___Pain ___Numbness ___Weakness

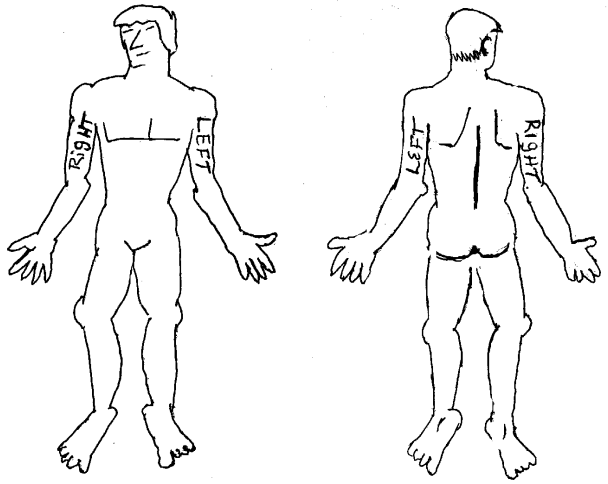
___Back pain Leg, buttock, or foot: ___Pain ___Numbness ___Weakness

___Other:_____

2. How long have you had this problem? _____
3. Has this problem recently gotten worse? **YES / NO** If YES, when? _____
4. What started the problem? _____

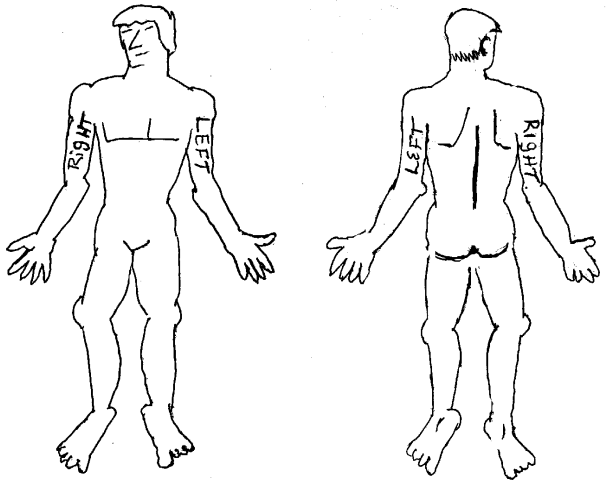
B. Pain and Numbness Diagrams

Mark where you have PAIN



Right Left Left Right

Mark where you have NUMBNESS or TINGLING



Right Left Left Right

My pain level is (circle one): 0 1 2 3 4 5 6 7 8 9 10

None Slight Moderate Severe Extreme Could not be worse

C. Complete this section for NECK/ARM problems ONLY.

1. What portion of your pain is in your **NECK versus your ARM(s)**? (Check only one)

___No neck or arm pain
___All NECK pain, no arm pain
___Mostly NECK pain, some arm pain
___NECK and ARM pain are about equal (50/50)
___Mostly ARM pain, only some neck pain
___All ARM pain, no neck pain

2. What portion of your **ARM PAIN** is on the **RIGHT versus LEFT**? (Check only one)

___No arm pain
___RIGHT arm pain, no left arm pain
___Mostly RIGHT arm pain, some left arm pain
___RIGHT and LEFT arms are about equal (50/50)
___Mostly LEFT arm pain, some right arm pain
___LEFT arm pain, no right arm pain

3. If you have **ARM PAIN**, where do you feel it? (Check all that apply)

RIGHT:__Shoulder __Arm __Forearm FINGERS: __Thumb __Index __Long __Ring __Small
LEFT: __Shoulder __Arm __Forearm FINGERS: __Thumb __Index __Long __Ring __Small

4. If you have **ARM NUMBNESS**, where do you feel it? (Check all that apply)

RIGHT:__Shoulder __Arm __Forearm FINGERS: __Thumb __Index __Long __Ring __Small
LEFT: __Shoulder __Arm __Forearm FINGERS: __Thumb __Index __Long __Ring __Small

5. If you have **ARM WEAKNESS**, where do you feel it? (Check all that apply)

RIGHT:__Shoulder __Arm __Forearm FINGERS: __Thumb __Index __Long __Ring __Small
LEFT: __Shoulder __Arm __Forearm FINGERS: __Thumb __Index __Long __Ring __Small

6. Are you **right- or left-handed**? (Circle one) **RIGHT** **LEFT**

7. Please indicate which, if any, of these problems you are experiencing. (Check all that apply)

___Pain or numbness that is *worse at night* than during the day
___Pain or numbness that is *worse with overhead activity* (e.g., washing or drying hair)
___Difficulty *picking up small objects* (e.g., keys, coins) or *buttoning shirts*
___New difficulty with *handwriting or penmanship*
___Problems with *balance or frequent tripping*
___Headaches in the *back of the head*

D. Complete this section for BACK/LEG problems ONLY.

1. What portion of your pain is in your **BACK versus your LEG(s)**? (Check only one)

___No back or leg pain
___All BACK pain, no leg pain
___Mostly BACK pain, some leg pain
___BACK and LEG pain are about equal (50/50)
___Mostly LEG pain, only some back pain
___All LEG pain, no back pain

2. What portion of your **LEG PAIN** is on the **RIGHT versus LEFT**? (Check only one)

___No leg pain
___RIGHT leg pain, no left leg pain
___Mostly RIGHT leg pain, some left leg pain
___RIGHT and LEFT legs are about equal (50/50)
___Mostly LEFT leg pain, some right leg pain
___LEFT leg pain, no right leg pain

3. If you have **LEG PAIN**, where do you feel it? (Check all that apply)

RIGHT:__Buttock __Groin __Front of thigh __Side of thigh __Back of thigh __Calf __Foot
LEFT: __Buttock __Groin __Front of thigh __Side of thigh __Back of thigh __Calf __Foot

4. If you have **LEG NUMBNESS**, where do you feel it? (Check all that apply)

RIGHT:__Buttock __Groin __Front of thigh __Side of thigh __Back of thigh __Calf __Foot
LEFT: __Buttock __Groin __Front of thigh __Side of thigh __Back of thigh __Calf __Foot

5. If you have **LEG WEAKNESS**, where do you feel it? (Check all that apply)

RIGHT:__Buttock __Groin __Front of thigh __Side of thigh __Back of thigh __Calf __Foot
LEFT: __Buttock __Groin __Front of thigh __Side of thigh __Back of thigh __Calf __Foot

6. How far can you walk before **LEG PAIN** makes you stop and rest? (Check only one)

___I cannot stand up
___Across the room
___Across the parking lot
___1 or 2 blocks
___1 or 2 miles
___I can walk as far as I want without leg pain

7. Is there anything else that keeps you from **WALKING** very far? (Check all that apply)

___Back pain
___Chest pain
___Shortness of breath
___Poor balance

8. What happens to your **LEG PAIN** with the following activities? (Check all that apply)

Lying down: __Better __Worse __No change
Sitting: __Better __Worse __No change
Standing: __Better __Worse __No change
Walking: __Better __Worse __No change
Bend forward: __Better __Worse __No change
Bend back: __Better __Worse __No change

9. What happens to your **BACK PAIN** with the following activities? (Check all that apply)

Lying down:	__Better	__Worse	__No change	*Walking*:	__Better	__Worse	__No change
Sitting:	__Better	__Worse	__No change	*Bend forward*:	__Better	__Worse	__No change
Standing:	__Better	__Worse	__No change	*Bend back*:	__Better	__Worse	__No change
Coughing:	__Better	__Worse	__No change	*Sneezing*:	__Better	__Worse	__No change

E. All patients should answer the following questions.

1. Are you **RECENTLY** leaking either urine or stool? **YES / NO** If YES, since when? _____
2. Are you **RECENTLY** straining to urinate? **YES / NO** If YES, since when? _____
3. Have you missed any work/school due to this problem? **YES / NO** How much? _____
4. Treatments for this particular problem have included: (Check all that apply)

___Supervised physical therapy
Where? _____
___Manipulation or chiropractic treatment
Where? _____
___Daily neck/back exercises
___Massage and ultrasound
___Traction, VAX-D, or DRX-9000
___TENS unit or RS muscle stimulator
___Back brace or neck collar

___Anti-inflammatory medication
___Narcotic pain medication
___Epidural steroid injections:_____times
How long did relief last? _____
___Facet joint injections/ablations:_____times
How long did relief last? _____
___Trigger point injections:_____times
How long did relief last? _____
___Other:_____

5. List pain medicines and dose taken for this problem: ___NONE _____

_____

_____

6. Previous doctors seen specifically about this problem: ___NONE

Doctor's Name	Specialty	City (if not Rockford)	Treatments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. What tests have you had for your problem? Please list the most recent date and location. ___ NONE

X-rays _____ MRI _____
Myelogram _____ EMG _____
CT scan _____ Bone scan _____

F. Past Medical History (Check all that apply) ___NONE

__Heart attack
__Angina
__Heart failure
__High blood pressure
__Stroke
__Vascular disease
__High cholesterol
__Organ transplants
__Diabetes
How long?_____

__Asthma
__Chronic bronchitis
__Emphysema
__Pneumonia, frequent
__Tuberculosis
__Dialysis
__Kidney stones
__Blood clot in legs
__Blood clot in lungs
__Bleeding disorders

__Sickle cell disease
__Anemia
__Stomach ulcers
__Hepatitis
__Parkinson's disease
__Seizure disorder
__Polio
__Neuropathy
__Alcoholism
__Mental illness

__HIV/AIDS
__Osteoporosis
__Fibromyalgia
__Rheumatoid arthritis
__Gout
__Lupus
__Ankylosing spondylitis
__Cancer of _____
__Injury of _____
__OTHER: _____

G. Past Surgical History (List all previous surgeries, especially any surgeries on neck, chest, or back; write on back if needed) ___NONE

Operation	Surgeon	Date

H. Review of Systems (Check all that apply) ___NONE

PATHOLOGIC
__Fevers or chills
__Night sweats
__Pain worse at night
__Unusual weight loss
__Sudden weight gain
__No position of relief
__Pain no better with rest
__Feel lump in buttock
__Feel lump in abdomen

CARDIOVASCULAR
__Heart or chest pain
__Abnormal heartbeat
__Swollen ankles or feet
__Freq. night urination
__Poor circulation
__Short of breath if flat
__Short of breath with exercise

PULMONARY
__Wheezing
__Persistent cough
__Green/yellow sputum
__Sinus infections
__Bad or loud snoring
__Frequent hoarseness
__Singing professionally

GASTROINTESTINAL
__Difficulty swallowing
__Nausea or vomiting
__Frequent diarrhea
__Blood in stool
__Very dark or tar stool
__Ulcers

NEUROLOGIC
__Burning pain
__Shingles/herpes zoster
__Change of vision
__Double vision
__Frequent headaches
__Blackouts or seizures
__Loss of memory
__Loss of hearing
__Ringing in ears
__Nervous exhaustion
__Depression or anxiety

HEMATOLOGIC
__Frequent nose bleeds
__Easy bruising/bleeding
__Gums bleed easily
__Blood clots in legs
__Blood clots in lungs

RHEUMATOLOGIC
__Bad morning stiffness
__Red or swollen joints
__Broken collarbone
__Rashes or skin changes
__New moles/dark spots

CONSTITUTIONAL
__Frequent infections
__Gum or tooth problems
__Anorexia or bulimia
__Poor nutrition
__Very low energy

GENITOURINARY
__Swollen lymph glands
__Difficulty urinating
__Burning on urination
__Frequent urination
__Blood in urine
__Leaking urine

WOMEN ONLY:
__Irregular periods
__Vaginal discharge
__Breast lumps or discharge

Have you ever had an infection with drug-resistant bacteria, e.g., methicillin-resistant staphylococcus (MRSA) or vancomycin-resistant enterococcus (VRE)? **YES / NO**

I. Family History (Check all that apply) ___NONE ___UNKNOWN

__Scoliosis
__Severe neck problems
__Severe back problems

__Cancer (Type_____)
__Heart attack
__Stroke

__Bleeding disorders
__Blood clots
__Kidney failure

__Diabetes
__Alcohol dependence
__Mental illness

J. Medications (List dose and schedule, write on back if needed) ___NONE

Any blood thinners (inc. aspirin)? **YES / NO** Any cholesterol-lowering medicines? **YES / NO**

List:_____ List: _____

Any osteoporosis medicines? **YES / NO** Are you taking calcium and vitamin D? **YES / NO**

List:_____ List: _____

OTHER: _____

_____

_____

_____

_____

K. Allergies to Medications ___NONE

Medication Type of Reaction (i.e., what happens?)

_____ _____

_____ _____

_____ _____

_____ _____

Any allergy to latex or bananas? **YES / NO** Any allergy to nickel or metals/jewelry? **YES / NO**

L. Social History:

1. Work status: ___Homemaker ___Student ___Working (list occupation):_____
   ___Retired ___Sick leave ___Not working
   ___On long-term disability or SSI ___Applying for long-term disability or SSI

2. Marital Status: ___Married ___Single ___Co-habitating
   ___Divorced ___Widowed

3. Number of living children:_____ Number of children living locally:_____

4. I live: ___Alone I live with:_____

5. Tobacco use:___Never ___Cigarettes ___Cigars ___Pipe ___Chew
   ___Packs per day for _____years ___I QUIT using tobacco ___years ago

6. Alcohol use: ___Never ___# of drinks per day ___# of drinks per week
   ___Alcoholic (drunk daily) ___Recovering alcoholic

7. Drug use: ___Never ___Currently ___Past ___Former addict/rehab patient

8. Because of this problem, I HAVE FILED a: ___Lawsuit ___Workers' compensation claim

9. Because of this problem, I MAY / WILL FILE a: ___Lawsuit ___Workers' compensation claim

Patient Signature:_____ **Date:**_____

Pediatric and Adolescent Scoliosis/Kyphosis Questionnaire

Only fill out this form if you are seeing the doctor for SCOLIOSIS or KYPHOSIS.

NAME:_____ DATE:_____

BIRTHDATE:_____ AGE:_____ HEIGHT:____ft. ____in. WEIGHT:_____lbs.

Approximate growth in last 6 months: _____

Height of mother: _____

Height of father: _____

Height of siblings: _____

Any relatives with scoliosis/kyphosis? _____

How was scoliosis/kyphosis discovered? _____

Previous treatment for scoliosis/kyphosis _____

Previous surgeons seen for condition: _____

Have you had your first menses/period? **YES / NO** Approximate start date?_____

Are your menses/periods regular? **YES / NO**

How old was your mother when her menses/periods began?_____

How do you feel about how: **0 1 2 3 4 5 6 7 8 9 10**
your spine looks? No problem Somewhat unhappy Very unhappy