Current Symptoms

Where are you currently having symptoms? ______________________________
What date (approximately) did your present pain start? ______________________________
How (gradually, suddenly, surgery)?______________________________
My symptoms are currently: **Getting better / About the same / Getting worse**
Have you received any treatment for this problem? ______________________________
Have you ever had this problem before: **Yes / No**
If so, how was this problem treated?______________________________
How are you able to sleep at night? **Fine / Moderate difficulty / only with medication**
What makes your symptoms better?______________________________
What activities make your symptoms worse? ______________________________

Past Medical History: Please circle each condition that you have been told you have (or had)

Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Heart disease	Angina/Chest pain	Ulcers	Fibromyalgia
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Lung disease	Depression
Epilepsy	Multiple Sclerosis	Brain Injury	Allergies/asthma	Anxiety

Other (please list):

Circle all that apply:

Smoker: Y N
Packs per day_____ for _____ years
Pacemaker: Y N
Do you have a latex allergy? Y N

Do you drink alcohol: Y N
Drinks_____ per day / week / month
Do you take blood thinners? Y N
Pregnant: Y N

Have you had an x-ray, MRI, or other imaging study for the present problem? If so please list__________

____

CURRENTLY I am experiencing (circle all that apply):

Unexplained weight loss	Numbness or tingling	Fever/chills/sweats	Poor balance (falls)	Changes in appetite
Difficulty swallowing	Depression	Shortness of breath	Dizziness	Headaches
Changes in bowel or bladder function	Nausea/Vomiting	Increased pain at night	Double vision	Speech disturbance

Past Surgical History (list all and date)	

Please List All Current Medications (name, dosage, times per day)	

Over the last 2 weeks, how often have you been bothered by the following problems (check appropriate boxes)

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things?				
Feeling down, depressed, or hopeless?				

On the scales below, please circle the number which best represents the severity of your pain

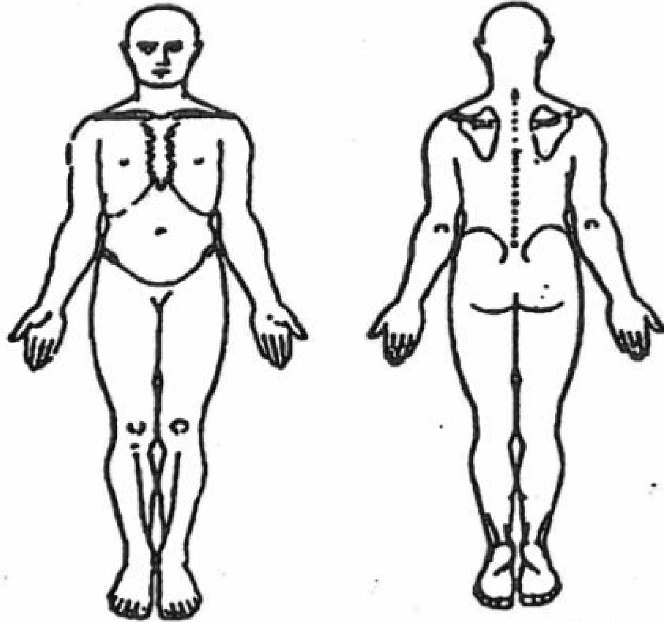
Worst for the past 48 hours:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Best for the past 48 hours:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Please mark on the body below the symptoms that represent your symptoms: Mark X for pain, O for weakness, /// for numbness/tingling



How would you rate your ability to perform routine daily activities?

Cannot do anything 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Able to do everything

How would you rate your ability to perform activities associated with your job?

Cannot do anything 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Able to do everything