PATIENT HISTORY FORM

Name: ______________________ Date: __________

Occupation: ______________________ Age: __________

1. When (roughly what date) did your present pain start?
____

2. How did it start? (Check appropriate box)
   - ☐ Lifting ☐ Pulling
   - ☐ Twisting ☐ Hit in the back
   - ☐ Fall ☐ Auto accident
   - ☐ Bending ☐ No accident

3. Your pain is worse in your: (Check appropriate boxes)
   - ☐ Back ☐ Back and hip(s)
   - ☐ Neck ☐ Down the leg(s)
   - ☐ Head ☐ All of these
   - ☐ Arm(s) ☐ None of these

4. How long have you been unable to work or do normal housework? ______________________

5. How long have you had any problem with your back, neck, legs, or arms? (Circle appropriate parts) ______________________

6. Your pain is: (Check appropriate boxes)

Better	Worse	No different	
☐	☐	☐	When coughing or sneezing
☐	☐	☐	Sitting in a straight chair
☐	☐	☐	Sitting in a soft easy chair
☐	☐	☐	Bending forward to brush your teeth
☐	☐	☐	When you wake up in the morning
☐	☐	☐	In the middle of the night
☐	☐	☐	Midday
☐	☐	☐	Lying flat on your back
☐	☐	☐	Lying flat on your stomach
☐	☐	☐	Lying on your side with your knees bent

7. Do you have to rest during the day because of your pain? (Check appropriate box)
   - ☐ No ☐ Half the day
   - ☐ A little ☐ More than half the day

8. Have you ever been in a hospital for back, leg, neck, or arm pain? ______________________
   Number of times: ______________________
   Give dates: ______________________

9. Have you ever had a myelogram (x-ray of the spine with dye injection)? ______________________
   Number of times: ______________________
   Give dates: ______________________

10. Have you ever had an electromyogram (EMG)? __________
    Number of times: __________ Give dates: __________

11. Have you ever had neck or back surgery? __________
    Number of times: __________
    Give types and dates: __________
    ____

12. Have you ever been in the hospital for other medical problems? __________ Number of times: __________
    Describe and give dates: __________

13. Do you exercise on a regular basis?
    ☐ Yes ☐ No

14. Please list the medicines you are currently taking: __________
    ____

15. What other medical problems do you have? (Check appropriate boxes)
    - ☐ Diabetes ☐ Stomach problems, ulcer, etc.
    - ☐ Arthritis ☐ Heart problems
    - ☐ Gout ☐ Epilepsy (fits)
    - ☐ Cancer ☐ Other

16. Please list any allergies you have: __________
    ____

17. Do you have an attorney helping you?
    ☐ Yes ☐ No

18. Do you want a report sent to your attorney?
    ☐ Yes ☐ No

19. Do other members of your family have significant back or neck trouble? __________
    Who (relationship)? __________

20. What treatments have made your pain better? __________
    ____
    What treatments have made your pain worse? __________
    ____

21. What is the most aggravating thing about your pain? __________
    ____

22. What brought you to this office? __________
    ____

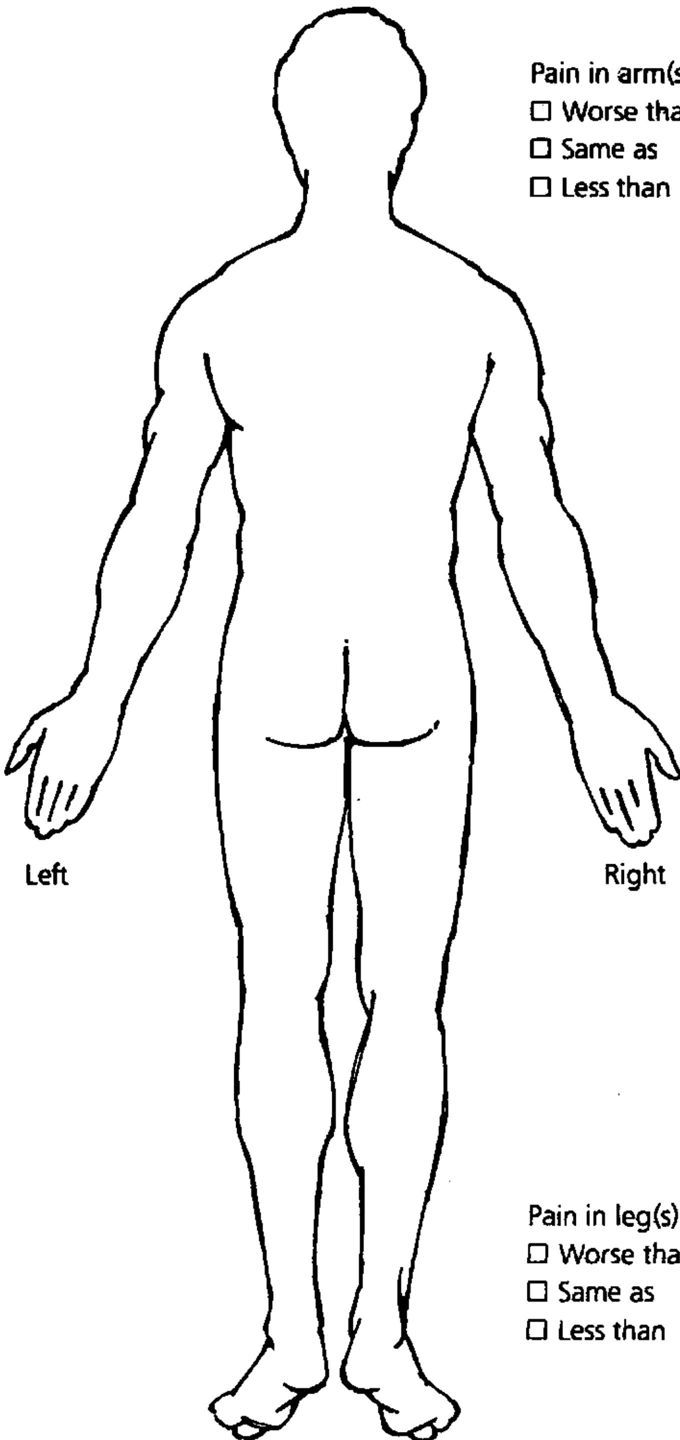
23. Please add any other information you would like to include, or additions to your answers to previous questions. __________
    ____
    ____
    ____
    ____

PATIENT PAIN DRAWING

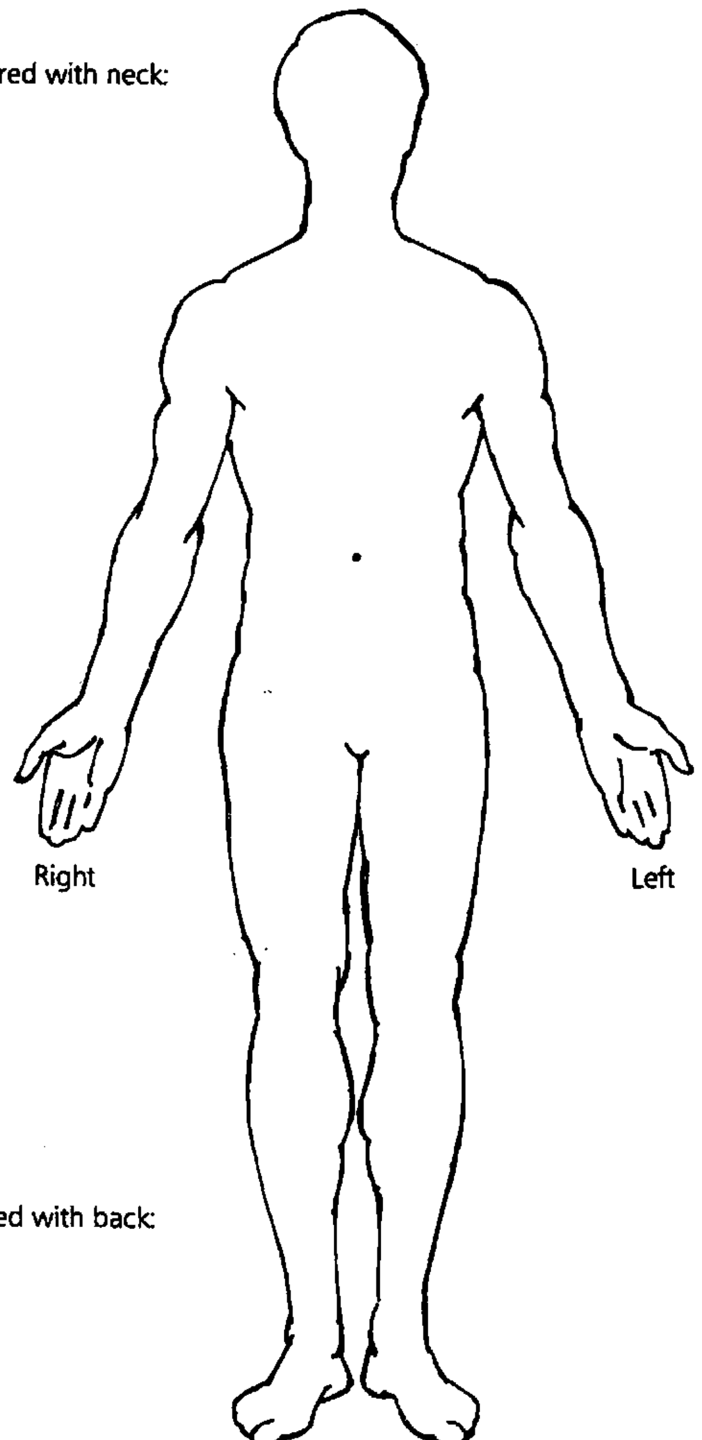
Name: ____ Date: ____________

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

Aching	Numbness	Pins and needles	Burning	Stabbing	Other
▲ ▲ ▲	= = =	○ ○ ○	× × ×	/ / /	● ● ●



Pain in arm(s) compared with neck:
- ☐ Worse than
- ☐ Same as
- ☐ Less than



Pain in leg(s) compared with back:
- ☐ Worse than
- ☐ Same as
- ☐ Less than