Reason for visit:_____
Have you been treated before for this problem? _____ Dr.(s):_____
What did they do or recommend?_____
When did symptoms first appear:_____
Is this condition getting progressively worse?_____
Are you pregnant? □ No □ Yes Do you have a pacemaker? □ No □ Yes_____
List surgeries, hospitalizations and/or traumas that you have had:_____
List any allergies that you have:_____
List prescription drugs and nutritional supplements you currently take:_____
Are your immunizations current for your age? □ No □ Yes_____
Date of last: Physical Exam_____ Blood Test _____ Chest X-Ray_____
Spinal Exam_____ Dental X-ray_____ MRI_____
CTScan_____ BoneScan_____
Describe the amount and intensity of exercise you get each week:_____
How many hours of sleep do you average per night?_____
What is your intake, if any of the following: In what form:
Caffeine: □ No □ Yes How much per day:_____
Tobacco: □ Never □ Present In what form:_____How much per day: _____
Recreational Drugs: □ Never □ Present What kind: □ Cocaine □ LSD □ Heroin □ Other:_____
Alcohol: □ Never □ Light □ Moderate □ Heavy

Family History: (List family members: Parents, Grandparents, Brothers, Sisters - do not include yourself)

Cancer: □ No □ Yes _____ Other:_____
Diabetes: □ No □ Yes_____
Asthma: □ No □ Yes _____
Arthritis: □ No □ Yes_____
Tuberculosis: □ No □ Yes _____
Kidney Disease: □ No □ Yes _____
High Blood Pressure: □ No □ Yes _____
Cardiovascular Disease: □ No □ Yes _____
Thyroid Disease/Goiter: □ No □ Yes _____
Muscle/Bone/Nerve Disease: □ No □ Yes _____

VISUAL ANALOG SCALE

The line below represents the intensity of *low back pain*. Please mark with an **X** at the position on the scale which indicates how much pain you feel at this time.

I----------I
No Pain ***Severe***

For Pain Other Than Low Back Location

I----------I
No Pain ***Severe***