STUART SPINE CENTER
Chiropractic & Rehabilitation

History of Illness / Injury / Pain

Name: _____ Todays Date: _____ Date of Injury (if known): _____

Location: Chief complaint and its location

_____

Timing and Duration:

How often do you experience this pain? Constant ___ Frequent ___ Intermittent ___ Occasional ___

What caused the onset? _____

_____

Severity: On a scale of 0 to 10, where 0 is no pain and 10 is excruciating pain, please answer the following questions

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10? _____

What is the least intense the symptom has been on a scale of 0 to 10? _____

What is the most intense the symptom has been on a scale of 0 to 10? _____

Associated Signs and Symptoms: Please check any that apply

Inflexibility ____ Stiffness ____ Spasms ____ Cramps ____

If this pain radiates or travels, please identify where to: _____

_____

Quality: Please check any that apply

How would you best describe the sensation of the pain/symptom:

Sharp ____ Stabbing ____ Aching ____ Pins & Needles ____ Pounding ____ Shooting ____

Burning ____ Dull ____ Tingling/Numb ____ Throbbing ____ Crawling ____ Stinging ____

Modifying Factors: Please check any that apply

What aggravates the pain / symptom?

Sneezing ___ Lifting ___ Exercising ___ Looking up/down ___ Walking ___ Coughing ___

Stooping ___ Looking side/side ___ Standing ___ Stress ___ Driving ___ Getting out of bed ___

Pushing ___ Pulling ___ Repetitive movement ___ Carrying ___ Straining at BM ___ Sitting ___

Other: _____

What relieves this pain/symptom?

Resting ___ Sleeping ___ Lifting ___ Exercising ___ Looking up/down ___ Shower ___ Advil ___

Stooping ___ Looking side/side ___ Mineral Ice ___

Other: _____

Over the past weeks/months this complaint is: Improving ___ Getting worse ___ About the same ___

Have you seen anyone for this condition? Yes ___ No ___ Whom? _____

How did you hear about us? _____

Doctor Signature: _____

Patient Signature: _____

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Name: _____ Todays Date: _____ Date of Injury (if known): _____

Secondary Complaint and Location:

Location: _____

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10? _____

What is the least intense the symptom has been on a scale of 0 to 10? _____

What is the most intense the symptom has been on a scale of 0 to 10? _____

Associated Signs and Symptoms: Please check any that apply

Inflexibility ___ Stiffness ___ Spasms ___ Cramps ___ Other: _____

Quality:

How would you best describe the sensation of the pain / symptom?

Sharp ___ Stabbing ___ Aching ___ Pins & Needles ___ Pounding ___ Shooting ___

Burning ___ Dull ___ Tingling/Numb ___ Throbbing ___ Crawling ___ Stinging ___

Over the past weeks/months this complaint has:

Improved ___ Worsened ___ Stayed about the same ___

Third Complaint and Location:

Location: _____

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10? _____

What is the least intense the symptom has been on a scale of 0 to 10? _____

What is the most intense the symptom has been on a scale of 0 to 10? _____

Associated Signs and Symptoms: Please check any that apply

Inflexibility ___ Stiffness ___ Spasms ___ Cramps ___ Other: _____

Quality:

How would you best describe the sensation of the pain / symptom?

Sharp ___ Stabbing ___ Aching ___ Pins & Needles ___ Pounding ___ Shooting ___

Burning ___ Dull ___ Tingling/Numb ___ Throbbing ___ Crawling ___ Stinging ___

Over the past weeks/months this complaint has:

Improved ___ Worsened ___ Stayed about the same ___

Key Value Questions:

What is your pain keeping you from doing that is the most important in your life?

_____

_____

What do you enjoy doing most in your life?

_____

_____

Doctor Signature: _____

Patient Signature: _____

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Name: _____ Todays Date: _____ Date of Injury (if known): _____

Please checkmark any condition that applies: P (Present), **N** (Not Present), **PP** (Present in the Past)

P	N	PP	Condition
			Fatigue
			Fever
			Chills
			Night Sweats
			Fainting
			Nervousness
			Concentration Loss
			Irritability
			Depression
			Memory Loss
			Headache
			Muscle Pain
			Muscle Weakness
			Muscle Cramps

P	N	PP	Condition
			Joint Stiffness
			Spinal Curvature
			Back Pain
			Hot Joints
			Joint Swelling
			Stiff Neck
			Lumps / Masses
			Seizures
			Dizziness
			Tremors
			Loss of Sensation
			Loss of coordination
			Paralysis
			Difficulty of Speech

Please checkmark any condition that applies: P (Present), **N** (Not Present), **PP** (Present in the Past)

F (Father), **M** (Mother), **B** (Brother), **S** (Sister), **GF** (Grandfather), **GM** (Grandmother)

P	N	PP	Condition	When and Explanation of Condition	F	M	B	S	GF	GM
			Cancer							
			Stroke							
			Thyroid							
			Asthma							
			Heart Attack							
			HIV							
			Chest Pain							
			Diabetes							
			Arthritis							
			Other							

Please list any known allergies: _____

_____

_____

Do you have a Pacemaker? Yes ___ No ___

Are you pregnant? Yes ___ No ___

Do you think you may be pregnant? Yes ___ No ___

Doctor Signature: _____

Patient Signature: _____

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Name: _____ Todays Date: _____ Date of Injury (if known): _____

Please list past surgeries:

1 _____ Year _____ 5 _____ Year _____
2 _____ Year _____ 6 _____ Year _____
3 _____ Year _____ 7 _____ Year _____
4 _____ Year _____ 8 _____ Year _____

List any other key slips, falls or accidents: (include date)	**Have you ever taken:**	**No**	**Yes**	**Year**
1.	Insulin			
2.	Cortisone			
3.	Thyroid Medicine			
4.	Male/Female Hormones			
5.	Blood Pressure			
6.	Tranquilizers/Sedatives			
7.	Birth control			

What medications are you currently taking? (include date)	
1.	4.
2.	5.
3.	6.

Do you have any known allergies to medications? _____

_____

Hospitalizations: _____

_____

Lifestyle:

Marital Status: Married ____ Divorced ____ Single ____ Separated ____ Widowed ____

Number of Children: ____ Children's Name(s): _____

Frequency of Exercise: Never ____ Rarely ____ Occasionally ____ Moderately ____ Regularly ____

Intensity of Exercise: Low level ____ Medium level ____ High level ____ Competition level ____

Sufficient Rest: Never ____ Rarely ____ Occasionally ____ Moderately ____

Hours of Sleep: Less than 6 ____ 6-8 ____ 8-10 ____ More than 10 ____

Well Balanced Diet: Never ____ Rarely ____ Occasionally ____ Moderately ____ Regularly ____

Do you smoke? No ____ Yes ____ Occasionally ____ **If yes/occasionally, how many per day?** ____

Caffeinated Beverages: No ____ Yes ____ Occasionally ____ **If yes/occasionally, how many per day?** ___

Alcoholic Beverages: No ____ Yes ____ Occasionally ____ **If yes/occasionally, how many per day?** ___

Have you ever used street drugs? No ____ Yes ____

Please your hobbies: _____

Doctor Signature: _____

Patient Signature: _____