Patient Information Form

The following information is needed in order to better serve you. Please complete all questions.

First Name _____ Middle Name _____ Last Name _____

Nick Name _____ SSN _____

Email _____

- ○ Send me appointment confirmations
- ○ Send me office news and updates

Address _____

City _____

State _____ Zip Code _____

Home Phone _____

Work Phone _____

Cell Phone _____

Gender ○ Male ○ Female

Birth Date _____

Occupation _____

Employer _____

Employers Address _____

Marital Status ○ Married ○ Single ○ Divorced

How did you hear about us?

○ Self-Referral ○ Screening ○ ECSC Website
○ Yelp / Google ○ Online Deal ○ Insurance Website
○ Existing Patient _____

Spouse's Name _____ Phone Number _____ Occupation _____

Spouse's Employer _____ Employer's Phone Number _____

Employer's Address _____

_____

Patient Condition Form

The following information is needed in order to better serve you. Please complete all questions.

Please describe your main complaint: _____

_____

Please describe how and when this problem started: _____

_____

Which of the following makes the symptoms better?

- ○ Rest
- ○ Medication
- ○ Sitting
- ○ Laying down
- ○ Standing
- ○ Other _____
- ○ Heat
- ○ Stretching
- ○ Ice
- ○ Walking
- ○ Movement

Which of the following makes the symptoms worse?

- ○ Rest
- ○ Medication
- ○ Sitting
- ○ Laying down
- ○ Standing
- ○ Other _____
- ○ Heat
- ○ Stretching
- ○ Ice
- ○ Walking
- ○ Movement

Describe your pain or symptoms

- ○ Sharp
- ○ Achy
- ○ Burning
- ○ Stabbing
- ○ Pin/Needles
- ○ Fatigue
- ○ Dizziness
- ○ Dull
- ○ Other: _____

How often do you experience your symptoms?

- ○ Constant (100-75%)
- ○ Frequent (74-50%)
- ○ Intermittent (49%-25%)
- ○ Occasional (24-1%)

Do the symptoms radiate anywhere?

- ○ Neck
- ○ Shoulder
- ○ Arm
- ○ Fingers
- ○ Leg
- ○ Knee
- ○ Ankle
- ○ Toes

How severe are the symptoms?

- ○ Minimal
- ○ Mild
- ○ Moderate
- ○ Severe

When do you experience symptoms?

- ○ Morning
- ○ Afternoon
- ○ Evening
- ○ All the time
- ○ Sporadically

When was the last time you experienced this? _____

Is the condition: ○ Improving ○ Staying the same ○ Worsening

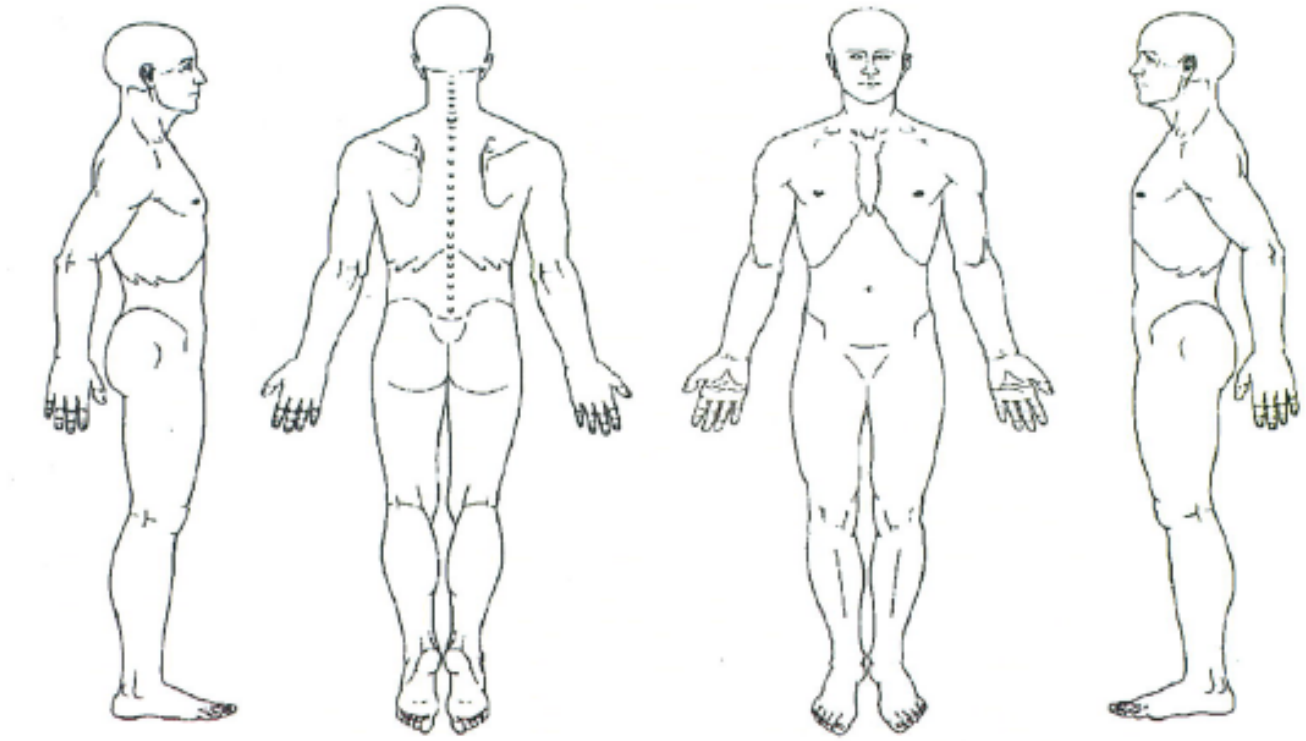
Patient Symptom Diagram

Indicate the location and type of symptoms that you are experiencing

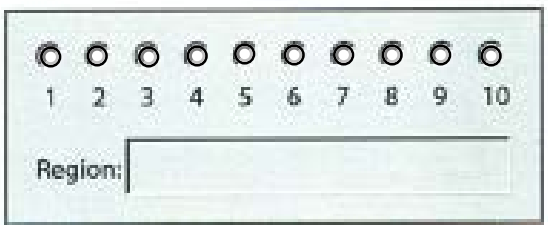
Please mark on the diagram the following

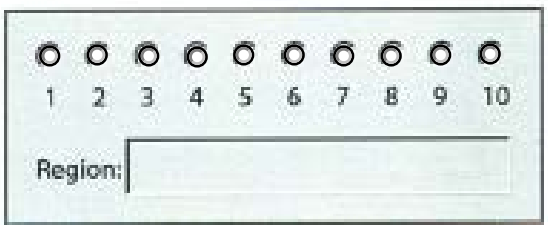
Numbness	= = = = =	Burning	x x x x x
Pins/Needles	o o o o o	Stabbing	/ / / / /
_____	^ ^ ^ ^ ^	Aching	a a a a a

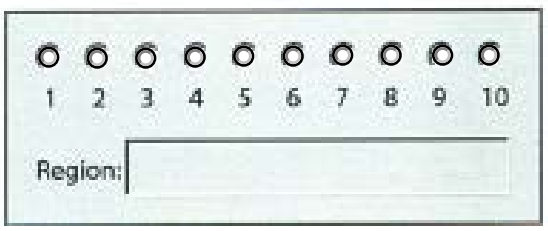
(Please describe the symptom)

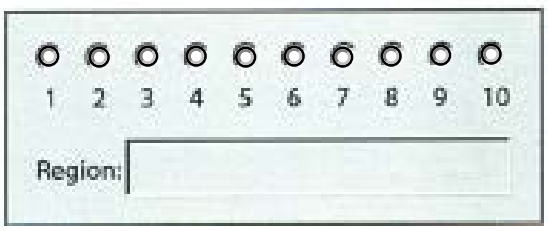


Please indicate the region of pain (ie. shoulder, legs, etc.) and its severity, with 10 being incapacitated









Bournemouth Questionnaire

Patient Name _____ Date_____

Instructions: The following scales have been designed to find out about your pain/discomfort and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your **pain/discomfort**?

   No pain Worst pain possible

   0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your pain/discomfort **interfered with your daily activities** (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

   No Interference Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your pain/discomfort **interfered with your ability** to take part in recreational, social, and family activities?

   No Interference Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, **how anxious** (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

   Not at all anxious Extremely anxious

   0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, **how depressed** (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

   Not at all depressed Extremely depressed

   0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have **you felt your work** (both inside & outside the home) has affected (or would affect) your pain?

   Have made it no worse Have made it much worse

   0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been **able to control** (reduce/help) your pain/discomfort on your own?

   Completely control it No control whatsoever

   0 1 2 3 4 5 6 7 8 9 10

_____ _____

Patient Signature **Total Score**

Other Comments:_____

With Permission from Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck/Back pain Patients *JMPT* 2002; 25 (3): 141-148

Please check the conditions you have or have had in the last year:

○ AIDS	○ Cancer	○ Diabetes	○ High Blood Pressure	○ Parkinson's Disease
○ Anemia	○ Epilepsy	○ Hypoglycemia	○ Chronic Fatigue	○ Depression
○ Arthritis	○ Polio	○ Fibromyalgia	○ Multiple Sclerosis	○ Rheumatic Fever
○ Stroke	○ Tuberculosis	○ Rheumatoid Arthritis		

Please check the conditions you have or have had in the past six (6) months:

General History

- O Trauma/Injuries
- O Weight changes
- O Fever/Chills/Sweats
- O HIV Positive
- O Allergies
- O Anemia
- O Bleeding/Bruising
- O Malaise/Fatigue/Weakness

Family History

- O Diabetes
- O Thyroid disease
- O Tuberculosis
- O Kidney disease
- O High blood pressure
- O Heart disease/Stroke
- O Musculoskeletal disease
- O Cancer

Endocrine System

- O Heat/Cold Intolerance
- O Thyroid problems
- O Diabetes
- O Hormone Therapy

Eye/Ear/Nose/Throat

- O Visual problems
- O Eye irritation
- O Pain in eyes
- O Other eye problems
- O Difficulty hearing / Deaf
- O Ringing in the ears
- O Dizziness
- O Ear pain
- O Nosebleeds
- O Change in ability to smell
- O Nose pain
- O Sinusitis
- O Other nose problems
- O Difficulty swallowing
- O Enlarged/Painful glands

Gastrointestinal System

- O Change in appetite
- O Food intolerance
- O Nausea/Vomiting
- O Indigestion/Heartburn
- O Abdominal pain
- O Abdominal swelling
- O Gas
- O Diarrhea/Constipation
- O Hernia
- O Gallbladder problems
- O Liver disease
- O Pancreatitis

Respiratory System

- O Difficulty breathing
- O Cough
- O Wheezing/Asthma
- O Tuberculosis/Exposure
- O Pneumonia/Lung infection
- O Cigarette smoking
- O Toxic fume exposure

Please check the conditions you have or have had in the past six (6) months:

Cardiovascular System

- O Shortness in breath
- O Chest discomfort / Pain
- O Palpitations
- O Edema / Swelling
- O Fainting
- O Calf pain while walking
- O High blood pressure
- O Heart disease
- O Cardiovascular surgeries
- O Other problems _____

Urinary System

- O Frequent urination
- O Painful urination
- O Changes in color
- O Difficulty starting
- O Difficulty holding
- O Discharge
- O Urinary tract infections
- O Kidney disease
- O Flank pain
- O Pelvic pain
- O Pelvic mass
- O Other problems _____

Reproductive System

- O Change in sex drive
- O Pain during sex
- O Birth control
- O Other sexual difficulties

Neurological System

- O Headaches
- O Epileptic seizures
- O Tics / Spasms
- O Dizziness / Fainting
- O Disturbances of sensation
- O Unusual weakness
- O Head trauma
- O Stroke
- O Other problems _____

Psychology History

- O Anxiety
- O Depression
- O Hospitalization / Therapy
- O Other problems _____

Musculoskeletal System

- O Joint stiffness
- O Joint pain
- O Joint swelling
- O Muscle cramps
- O Muscle weakness
- O Muscle wasting
- O Neck pain
- O Mid back pain
- O Low back pain
- O Sacroiliac pain
- O Tailbone pain
- O Arm problem
- O Leg problem
- O Fractures / Dislocations
- O Sprains / Strains
- O Other injuries

Examiner's Notes

Patient Health History

Use this space to further describe any of the conditions/symptoms listed previously or any condition other than that for which you are now consulting us:

For female patients only:

Menarche (1st period) Age _____ Year _____ Days in cycle: _____

Menstrual Cramping Pain
0 1 2 3 4 5

Menstrual Flow:
Scant ☐ Light ☐
Moderate ☐ Heavy ☐

Duration: _____

☐ Post-Menopausal bleeding ☐ Abdominal/Painful premenstrual fluid retention ☐ Other female problems

☐ Difficult delivery ☐ PMS ☐ Hysterectomy

Please list all medications you are currently taking (prescription or OTC) and the reason for taking them):

Name of medication:	Reason for taking medication:

Please fill out all applicable fields:

List any traumas and their dates (especially any head and neck injuries):

List any broken bones or dislocations:

List all surgeries and their dates:

Have you ever been unconscious, if so please explain:

List any other doctors seen, treatments, and results obtained: