LABEL, or:
Name: ______________________
DOB: _________ Date: _________

EVALUATION FORM

VISIT INFORMATION	Age: Height: Weight: Handedness: ☐ Right ☐ Left
Primary Care Provider:	Referring Provider:
What is the main reason for seeking medical attention today?	
When did this start?	
How did this start? ☐ Work-related ☐ Trauma ☐ Fall ☐ MVA ☐ Unknown ☐ Other	Further Details:

HISTORY *please check all that apply*

Describe your pain:

☐ Achy	☐ Burning	☐ Cramping
☐ Dull	☐ Numb	☐ Pressure
☐ Radiates	☐ Sharp	☐ Sore
☐ Squeezing	☐ Stabbing	☐ Tightening
☐ Throbbing	☐ Other:	

Please draw the location of your pain/discomfort:

Mark “P” for pain and “N” for numbness

Is your pain? ☐ Constant or ☐ Intermittent

Is your pain? ☐ Improving or ☐ Worsening or ☐ Stable

What makes the pain worse?

☐ Sitting ☐ Standing ☐ Walking ☐ Lying ☐ Moving
☐ Other

What makes the pain better?

☐ Sitting ☐ Standing ☐ Walking ☐ Lying ☐ Moving
☐ Other

What treatments have you tried for this problem?	**Helpful**	**Not Helpful**
Acupuncture		
Chiropractic		
Massage		
TENS		
Physical Therapy		
Psychology		
Braces		
Injections		
Surgery		
Other:		

Do you take any pain medications? ☐ **Yes** ☐ **No**

If yes, please list:

What medications have you previously tried for this problem?

What tests have you had for this problem?

☐ X-Rays ☐ CT Scan
☐ MRI ☐ EMG (nerve study)
☐ Other:

How bad is the pain? *Please use the scales below*

0	2	4	6	8	10
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST

No pain — Moderate pain — Worst pain

0 1 2 3 4 5 6 7 8 9 10

Are you experiencing any of the following?
Please check if present

Fever or Chills		Headaches	
Unexplained weight loss		Weakness	
Blurred vision		Numbness or tingling	
Difficult swallowing		Joint Swelling	
Shortness or breath		Arthritis	
Chest Pain		Depression	
Heart Palpitations		Anxiety	
Nausea or vomiting		Sleep Problems	
Black Stools		Dizziness	
Loss of bowel control		Easy Bleeding or blood thinners	
Loss of bladder control		Other:	
Skin Rash			

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PRESCRIPTION MEDICATIONS			OVER-THE-COUNTER & HERBAL MEDICINES *(vitamins, supplements, alternative medications)*		
☐ **See attached list**			☐ **See attached list**		
Name	Dose	Frequency	Name	Dose	Frequency

ALLERGIES & ADVERSE REACTIONS - *please list all allergies & reactions. Check "no allergies" if appropriate.*

☐ **See attached list** **or** ☐ **Already updated in electronic medical record**

Food:	Reaction:	☐ No Allergies
Medication:	Reaction:	☐ No Allergies
☐ Latex or ☐ Contrast dye:	Reaction:	☐ No Allergies
Other:	Reaction:	☐ No Allergies

PAST MEDICAL HISTORY *please check all that apply*

☐ Heart disease	☐ High blood pressure	☐ Arthritis	☐ Ulcers
☐ Diabetes	☐ Stroke	☐ Depression	☐ Migraines
☐ Lung disease	☐ Thyroid problems	☐ Asthma	☐ Cancer, type:
☐ Kidney disease	☐ Seizures	☐ Heartburn	☐ Osteoporosis
			☐ Other:

PAST SURGICAL HISTORY *please list type and date*

☐ Spine surgery *(please specify)*:

☐ Joint surgery *(please specify)*:

☐ Appendix	☐ Gall bladder	☐ Other:
☐ Hysterectomy	☐ Tonsillectomy	

FAMILY HISTORY *please list any important diseases that run in your family and who is affected*

☐ **Already updated in electronic medical record**	☐ Stroke	☐ Cancer, type:	☐ Osteoporosis
☐ Heart disease	☐ Depression	☐ High blood pressure	☐ Other:
☐ Diabetes	☐ Rheumatoid arthritis	☐ High cholesterol	

SOCIAL HISTORY

Occupation: **Status:** *(circle one)* Full-time / Part-time / Restricted-duty / Off-duty from injury / Retired / Not working

Is there litigation related to your back (or neck) condition? ☐ Yes ☐ No

Tobacco Use:	☐ Never Used	☐ Former User → Years of Use:	Quit Date:
	☐ Inhale Second-hand Smoke	☐ Current User → Years of Use:	Packs/Day:
	If you smoke currently, do you want to quit?	☐ Yes ☐ No ☐ N/A	

Type of Tobacco: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco

Alcohol Use: ☐ No ☐ Yes → Number of Drinks Per Week: ☐ Wine ☐ Beer ☐ Shots of Liquor

Other Substances Used: ☐ Marijuana ☐ Other: Times Per Week:

Do you exercise? ☐ Yes ☐ No **If yes, what do you do? How often?**

SCREENING QUESTIONS *please check all that apply to you*

Have you had any falls in the past 3 months?	☐ **Yes**	**Do you have a fear that you may fall?**	☐ **Yes**
Are you having difficulty walking?	☐ **Yes**	**In the past 2 weeks, have you felt down, depressed or hopeless?**	☐ **Yes**

PATIENT LEARNING/EDUCATION

Are there any? (mark all that apply)

☐ Cultural / social / spiritual barrier to learning about your condition

☐ Physical barriers to learning about your condition

I want to learn more about my medical condition(s)? ☐ Yes ☐ No

How do you learn best?

☐ Listening ☐ Reading ☐ Demonstration / Visual

Highest grade completed?

☐ Grade School ☐ High School ☐ Postgraduate

ADVANCE DIRECTIVE

Do you have a Living Will?	☐ Yes ☐ No ☐ Need info
Do you have a Medical Power of Attorney	☐ Yes ☐ No ☐ Need info
Do you have an Advanced Directive?	☐ Yes ☐ No ☐ Need info

NUTRITION

Please mark all that apply to you:

☐ Inability to eat	☐ Pregnant or lactating
☐ Unintentional weight loss	☐ Unintentional weight gain

HAVE YOU BEEN HIT, SLAPPED, KICKED OR IN ANY WAY ABUSED THIS PAST YEAR? ☐ Yes ☐ No