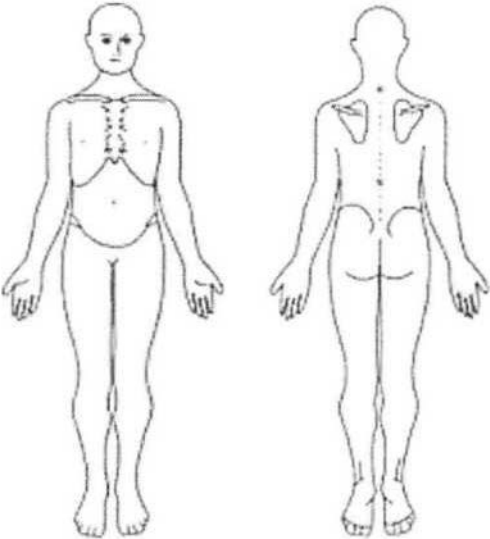
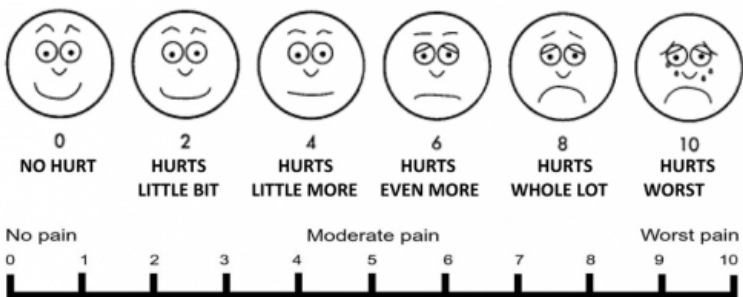


LABEL, or:	
Name: _____	
DOB: _____	Date: _____

### EVALUATION FORM

<b>VISIT INFORMATION</b>	Age:	Height:	Weight:	Handedness: <input type="checkbox"/> Right <input type="checkbox"/> Left
Primary Care Provider:	Referring Provider:			
What is the main reason for seeking medical attention today?				
When did this start?				
How did this start? <input type="checkbox"/> Work-related <input type="checkbox"/> Trauma <input type="checkbox"/> Fall <input type="checkbox"/> MVA <input type="checkbox"/> Unknown <input type="checkbox"/> Other    Further Details:				
<b>HISTORY</b> <i>please check all that apply</i>				
Describe your pain:				
<input type="checkbox"/> Achy	<input type="checkbox"/> Burning	<input type="checkbox"/> Cramping		
<input type="checkbox"/> Dull	<input type="checkbox"/> Numb	<input type="checkbox"/> Pressure		
<input type="checkbox"/> Radiates	<input type="checkbox"/> Sharp	<input type="checkbox"/> Sore		
<input type="checkbox"/> Squeezing	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Tightening		
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Other:			
<b>Please draw the location of your pain/discomfort:</b>				
Mark "P" for pain and "N" for numbness				
				
<b>Is your pain?</b> <input type="checkbox"/> Constant    or <input type="checkbox"/> Intermittent				
<b>Is your pain?</b> <input type="checkbox"/> Improving    or <input type="checkbox"/> Worsening    or <input type="checkbox"/> Stable				
<b>What makes the pain worse?</b>				
<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lying <input type="checkbox"/> Moving				
<input type="checkbox"/> Other				
<b>What makes the pain better?</b>				
<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lying <input type="checkbox"/> Moving				
<input type="checkbox"/> Other				
<b>What treatments have you tried for this problem?</b>		<b>Helpful</b>	<b>Not Helpful</b>	
Acupuncture				
Chiropractic				
Massage				
TENS				
Physical Therapy				
Psychology				
Braces				
Injections				
Surgery				
Other:				
<b>Do you take any pain medications?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please list:				
What medications have you previously tried for this problem?				
<b>What tests have you had for this problem?</b>				
<input type="checkbox"/> X-Rays		<input type="checkbox"/> CT Scan		
<input type="checkbox"/> MRI		<input type="checkbox"/> EMG (nerve study)		
<input type="checkbox"/> Other:				
<b>How bad is the pain? Please use the scales below</b>				
				
<b>Are you experiencing any of the following?</b> <i>Please check if present</i>				
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				



LABEL, or:	
Name: _____	
DOB: _____	Date: _____

PRESCRIPTION MEDICATIONS	OVER-THE-COUNTER & HERBAL MEDICINES <i>(vitamins, supplements, alternative medications)</i>
<input type="checkbox"/> See attached list	<input type="checkbox"/> See attached list
Name                      Dose                      Frequency	Name                      Dose                      Frequency

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

<input type="checkbox"/> See attached list      or <input type="checkbox"/> Already updated in electronic medical record	
Food:	Reaction: <span style="float: right;"><input type="checkbox"/> No Allergies</span>
Medication:	Reaction: <span style="float: right;"><input type="checkbox"/> No Allergies</span>
<input type="checkbox"/> Latex      or <input type="checkbox"/> Contrast dye:	Reaction: <span style="float: right;"><input type="checkbox"/> No Allergies</span>
Other:	Reaction: <span style="float: right;"><input type="checkbox"/> No Allergies</span>

**PAST MEDICAL HISTORY** please check all that apply

<input type="checkbox"/> Heart disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Depression	<input type="checkbox"/> Migraines
<input type="checkbox"/> Lung disease	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer, type:
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Osteoporosis

**PAST SURGICAL HISTORY** please list type and date

<input type="checkbox"/> Spine surgery (please specify):	<input type="checkbox"/> Other:
<input type="checkbox"/> Joint surgery (please specify):	
<input type="checkbox"/> Appendix <input type="checkbox"/> Gall bladder <input type="checkbox"/> Other:	
<input type="checkbox"/> Hysterectomy <input type="checkbox"/> Tonsillectomy	

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

<input type="checkbox"/> Already updated in electronic medical record	<input type="checkbox"/> Stroke	<input type="checkbox"/> Cancer, type:	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Depression	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Other:
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> 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

<b>Have you had any falls in the past 3 months?</b> <input type="checkbox"/> Yes	<b>Do you have a fear that you may fall?</b> <input type="checkbox"/> Yes
<b>Are you having difficulty walking?</b> <input type="checkbox"/> Yes	<b>In the past 2 weeks, have you felt down, depressed or hopeless?</b> <input type="checkbox"/> Yes

**PATIENT LEARNING/EDUCATION**

Are there any? (mark all that apply)	How do you learn best?
<input type="checkbox"/> Cultural / social / spiritual barrier to learning about your condition	<input type="checkbox"/> Listening <input type="checkbox"/> Reading <input type="checkbox"/> Demonstration / Visual
<input type="checkbox"/> Physical barriers to learning about your condition	Highest grade completed?
I want to learn more about my medical condition(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Grade School <input type="checkbox"/> High School <input type="checkbox"/> Postgraduate

**ADVANCE DIRECTIVE**

Do you have a Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need info	<b>NUTRITION</b> Please mark all that apply to you:
Do you have a Medical Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need info	
Do you have an Advanced Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need info	

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