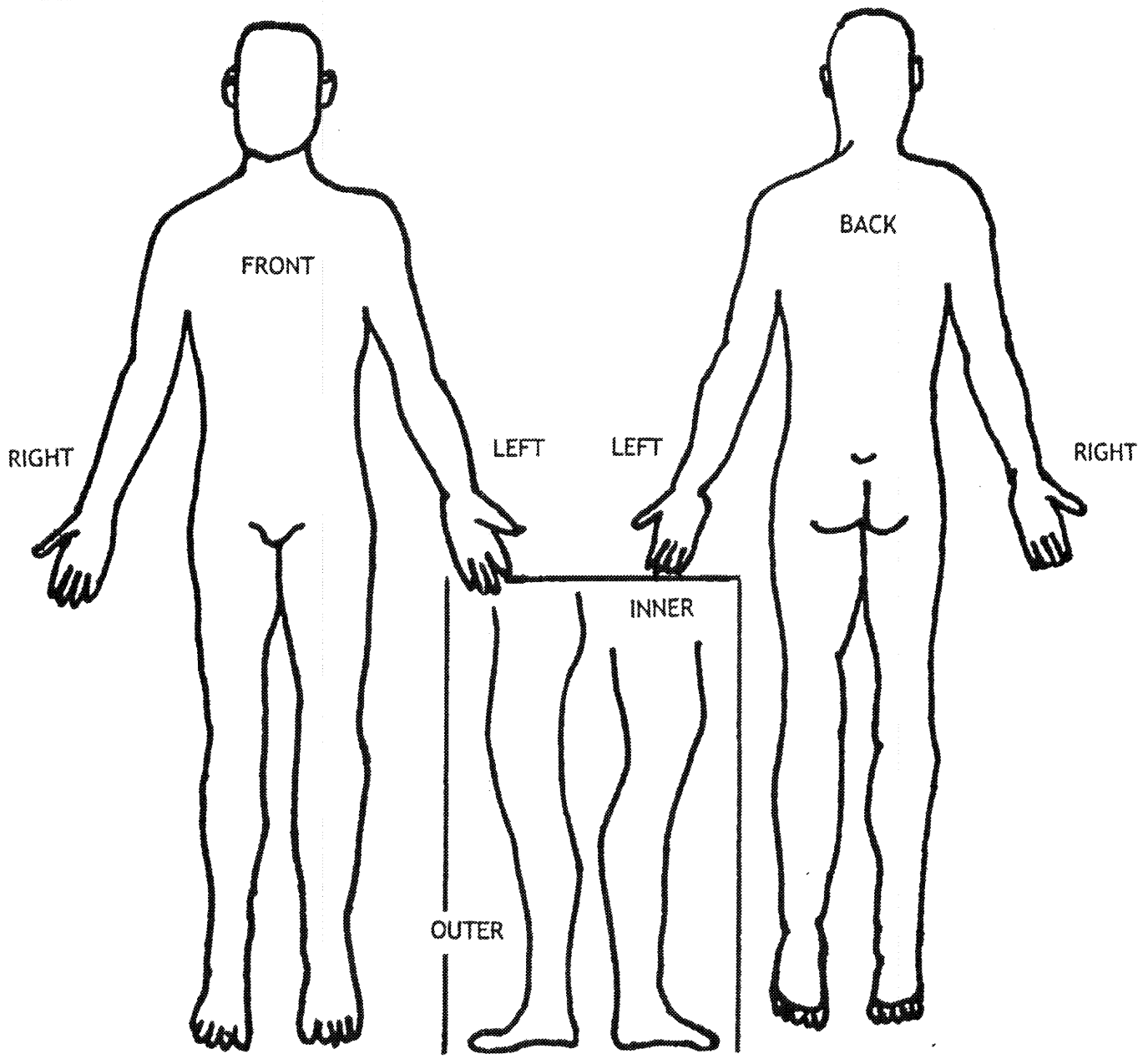


BODY PICTURE

NAME: _____ DATE: _____

Please mark the areas of your body where you feel your sensation. Be sure to use the appropriate symbol. Include all affected areas.

Numbness =====	Pins & Needles ooo ooo ooo ooo	Burning xxx xxx xxx xxx	Stabbing/Sharp /// /// /// /// /// ///	Ache/Dull vvv vvv vvv vvv vvv vvv
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Name _____ Age _____ Date _____
 Referred by _____ Employer _____
 Family Physician _____ Job Title _____
 Date of Injury _____

Describe Where You Hurt:

- 1.
- 2.
- 3.
- 4.
- 5.

Describe How Your Pain Started:

What Doctors Have You Seen?

Indicate Any Treatments or Tests You've Had--

- | | |
|-----------------------------------|----------------------------|
| ___ Physical Therapy (When _____) | For How Long? _____ |
| ___ Epidural steroid Injections | ___ MRI Scan (Date _____) |
| ___ Trigger Point Injections | ___ CT Scan (Date _____) |
| ___ Back Brace | ___ Myelogram (Date _____) |
| ___ Neck Collar | ___ EMG Test (Date _____) |
| ___ Chiropractic | ___ Discogram (Date _____) |
| ___ No Treatment | ___ Bone Scan (Date _____) |
| | ___ No Tests |

What Medications Have You Tried? _____

Did You Have Any Pain or Problems Before Your Accident or Injury? Yes No
 If Yes, Where Was Your Pain? _____

How Does Your Current Pain Compare to Your Pain Before the Injury? _____

How Are You Currently Being Treated?

- | | |
|---------------------------------|----------------------------|
| ___ Physical Therapy | ___ Home Exercise Program |
| ___ Medication | ___ Chiropractic |
| ___ Epidural Steroid Injections | ___ Collar |
| ___ Back Bracing | ___ No Treatment |
| | ___ Other (explain: _____) |

Name of Physicians Currently Treating You: _____

How Severe is Your Pain on a Scale of 1 - 10? (1=very mild pain; 10=very severe pain)
 On Your Worst Day _____ On Your Best Day _____

What Activities Improve Your Pain?

____ Sitting • ____ Standing • ____ Walking • ____ Driving • ____ Lifting • ____ Bending/Twisting
 ____ Cough • ____ Other: _____

What Activities Make Your Pain Worse?

____ Sitting • ____ Standing • ____ Walking • ____ Driving • ____ Lifting • ____ Bending/Twisting
 ____ Cough • ____ Other: _____

Do You Have Problems Controlling Your Bowel or Bladder? Yes No

Does Your Pain Awaken You From a Deep Sleep? Yes No

Are You Currently Working? Yes No Retired
 What Are Your Job Duties? _____

Who Is Your Attorney? _____ or Attorney is Not Involved

Current Medications: (List)

Name

Dose

Are You Allergic to Any Medications? (List)

Name

Reaction

Have You Ever Had Any Health Problems?

- | | | | |
|--|-----------------------|--|----------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Clots in Legs |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Ulcers |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma/Lung Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer (Where? _____) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: _____ |

Females Only:

Is There a Chance You Could Be Pregnant? Yes No

Have You Been Through Menopause? Yes No

If You Are Less than 21 Years Old, When Was Your First Menstrual Period? _____

Have You Had Back/Neck Surgery?

Yes No

If Yes, Provide Type/When/Surgeon:

Type

When

Who Was Your Surgeon?

Have You Ever Had Surgery of Any Kind?

Do You Smoke? Yes No Amount _____ Do You Drink Alcohol? Yes No Amount: _____

Marital Status: Married Divorced Single Widowed Number of Children: _____

Family Health History

Parent's Health Problems _____

Brothers/Sisters Health Problems _____

Grandparents Health Problems _____

Describe Any Spine Related Problems in the Family _____

Do You Currently Have Any of the Following?

- | | | | | | |
|--|--------------|--|----------------------|--|---------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Cold | <input type="checkbox"/> Yes <input type="checkbox"/> No | Valley Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diarrhea |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Sore Throat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Constipation |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear Ache | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bloody Stools |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Headache | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bladder Incontinence | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest Pain |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Nose Bleeds | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bowel Incontinence | <input type="checkbox"/> Yes <input type="checkbox"/> No | Indigestion |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Faintness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ankle Swelling | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Pain |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fibromyalgia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Stone | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression |

Your Height: _____

Your Current Weight: _____