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ALTERNATIVES

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INITIAL QUESTIONNAIRE

Name: ______________________ Age: ___ Sex: M F DOB: ________ Today's date: ________________

Insurance Company: ______________________ Height: ___________ Weight: ________________

Employer: ______________________ Occupation: ______________________

Are you working: (circle one) Full-time Part-time Unemployed Retired

How did you learn about us? ______________________ Who referred you to us? ______________________

CHIEF REASON FOR TODAY'S VISIT:

____

____

When did this problem start? ______________________

If it was an injury, please describe how it happened: ______________________

_ ______________________

_ ______________________

_ ______________________

_ ______________________

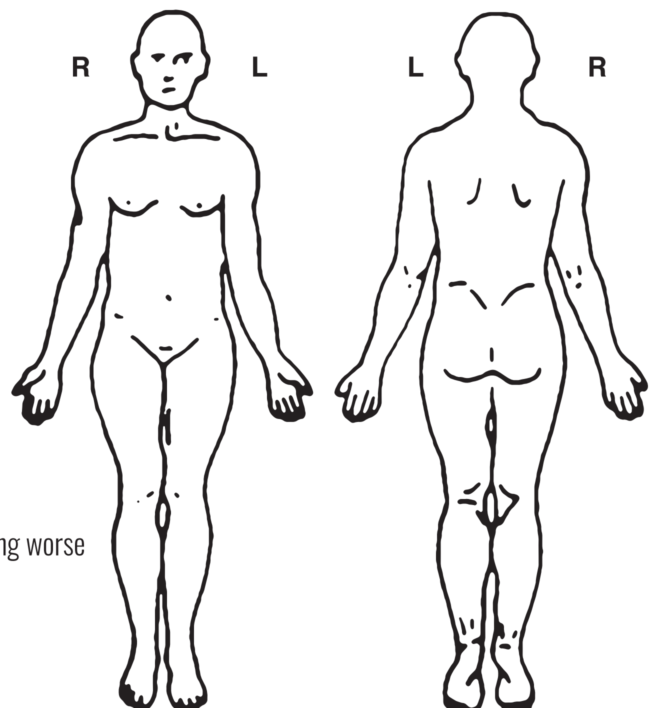
_ ______________________

CURRENT COMPLAINTS (In order of severity)

1.

2.

3.



Indicate on the diagram at the right where the pain is located.
(Mark x's for areas of pain, o's for areas of numbness or tingling.)

Grade the severity of the pain by circling the number that corresponds with the current level:

0 1 2 3 4 5 6 7 8 9 10

(0 = no pain, 10 = worst possible pain)

The pain is currently: (please check) ❑ Constant ❑ Intermittent ❑ Brief

Recently, the pain has been: ❑ Getting better ❑ Staying the same ❑ Getting worse

How would you best describe your pain? (check all that apply)

❑ Sharp ❑ Deep aching ❑ Burning
❑ Stabbing ❑ Cramping ❑ Tingling
❑ Localized ❑ "It hurts all over" ❑ "Lightning strike"

ASSOCIATED SYMPTOMS: (please check)

❑ Numbness ❑ Weakness of arms or legs ❑ Loss of bowel or bladder control

When is the pain the worst? (please check)

❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ No pattern

What is making the pain worse? (check all that apply)

❑ Bending ❑ Coughing ❑ Jarring ❑ Sitting ❑ Lifting ❑ Sneezing ❑ Tension
❑ Standing ❑ Reaching ❑ Bowel movements ❑ Stress ❑ Walking ❑ Twisting

❑ Other activities: ______________________________

Which is the worst? ______________________________

What activities cause your pain/symptoms? ______________________________

What activities relieve your pain/symptoms? ______________________________

What exercises or activities do you enjoy? ______________________________

What exercises or activities are you unable to do because of pain? ______________________________

What is your primary objective or goal for your treatment? ______________________________

How will you define treatment success? (please circle)

Freedom from all pain. Y N
Any amount of pain relief Y N
Doing all desired activities. Y N
Tolerating simple activities Y N

Other? ______________________________

What has been tried to help with the pain? (Please circle correct response)

	Tried?	Helpful?		Tried?	Helpful?
Physical Therapy	Yes/No	Yes/No	Brace or splint	Yes/No	Yes/No
Traction	Yes/No	Yes/No	Home exercises	Yes/No	Yes/No
Ultrasound	Yes/No	Yes/No	Pool exercises	Yes/No	Yes/No
TENS unit	Yes/No	Yes/No	Medications	Yes/No	Yes/No
Massage Therapy	Yes/No	Yes/No	Heat	Yes/No	Yes/No
Acupuncture	Yes/No	Yes/No	Ice (cold packs)	Yes/No	Yes/No
Chiropractic treatment	Yes/No	Yes/No	Restriction of activities	Yes/No	Yes/No
Injections	Yes/No	Yes/No			
Prolotherapy	Yes/No	Yes/No	Other ______________		Yes/No

Which is / has been the most helpful? ______________________________

Which of these are you doing currently? ______________________________

Name of practitioner for current therapy? ______________________________

PREVIOUS TREATMENTS / DIAGNOSTIC TESTING

List any physicians / specialists you have seen for this condition: ______________________________

X-rays (results & date) ______________________________

MRI (results & date) ______________________________

Other test results & dates ______________________________

____

NOTE: Please bring pertinent x-ray/MRI films and written reports with you to your appointment.

PAST MEDICAL HISTORY:

Have you had any of the following medical conditions? (please check)

❏ Severe childhood disease ❏ Heart disease ❏ Diabetes ❏ Polio
❏ High blood pressure ❏ Kidney disease ❏ Ulcers ❏ Stroke
❏ Arthritis ❏ Cancer ❏ Endometriosis
❏ Fractures________________ ❏ Other conditions: ________________
❏ Previous neck pain or injuries ❏ Previous back pain or injuries

Have you ever been treated for chemical dependency? ❏ Yes ❏ No If so, when? ________________

Have you ever had back or neck spinal surgery? ❏ Yes ❏ No If so, when? ________________

Have you had any other type of surgery? ❏ Yes ❏ No If so, what type?________________

SOCIAL HISTORY:

Marital status:________________ Highest level of education: ________________

HEALTH HABITS:

Do you smoke? ❏ No ❏ Yes (If so, ________ packs per day)

Do you drink alcohol? ❏ No ❏ Yes (If so, ________/ per day or ________/ week or ________/ month)

Do you drink coffee or caffeinated beverages? ❏ No ❏ Yes (If so, ________ cups/cans/bottles per day)

Do you regularly exercise? ❏ No ❏ Yes How often do you exercise? ________ X per week

If so, please check what kind you do: ❏ Walking ❏ Aerobics class ❏ Yoga ❏ Swimming ❏ Stationary bike ❏ Running
❏ Weight training ❏ Qigong
❏ Other: ________________

How would you rate your current stress level? (example: personal, job financial, etc.) Type:________________
❏ None ❏ Mild ❏ Moderate ❏ Severe ❏ Extreme

Do you regularly engage in prayer, meditation or other spiritual practice? Type: ________________

Would you like prayer for healing or other needs? (Dr. Kramer prays with patients if they desire it) ❏ Yes ❏ No

REVIEW OF OTHER SYSTEMS:

Have you had any of the following symptoms recently? (please check)

❏ Unexplained weight los ❏ Kidney or urinary tract problems ❏ Unexplained fever or night sweats
❏ Swelling of joints or legs ❏ Severe night pain awakening you ❏ Neurologic condition
❏ Migraine headaches or other headaches ❏ Depression or mood swings ❏ Ear, nose or throat problems
❏ Fatigue ❏ Stomach and digestive problems/ulcers ❏ Skin rashes
❏ Heart condition or racing heart ❏ Bleeding tendencies / anemia ❏ Respiratory problems

❏ Other: ________________

MEDICATIONS: What do you currently take and how often?

Current Pain Mediations (include dosages)	Past Pain Mediations (include dosages)	Other Pain Mediations (include dosages)	Vitamins/Supplements (include ingredients & dosages)

Do you have ANY ALLERGIES OR ADVERSE REACTIONS TO MEDICATIONS? ❏ YES ❏ NO

If so, to which ones and describe reaction: ________________