



### 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**

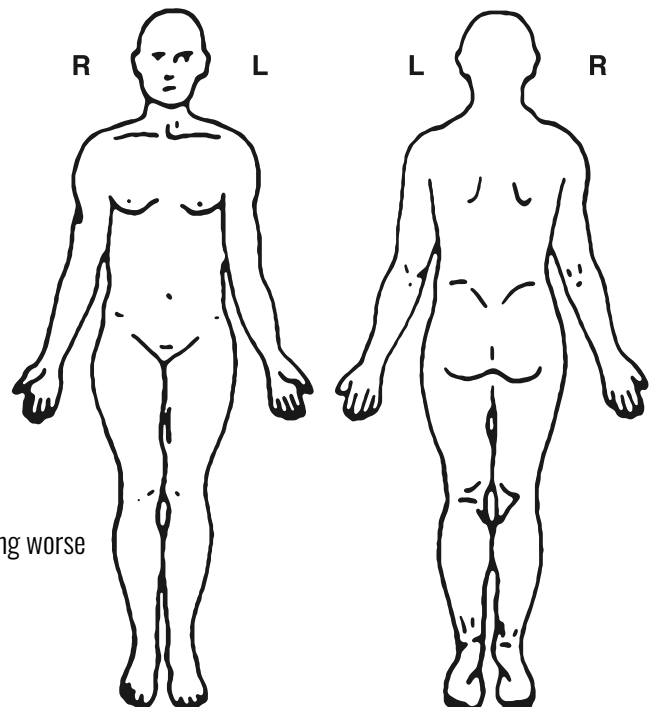
(0 = no pain, 10 = worst possible pain)

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

Other? \_\_\_\_\_

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

	<b>Tried?</b>	<b>Helpful?</b>		<b>Tried?</b>	<b>Helpful?</b>
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 loss       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 Medications (include dosages)	Past Pain Medications (include dosages)	Other Medications (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:** \_\_\_\_\_