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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:_____

_____

_____

_____

_____

_____

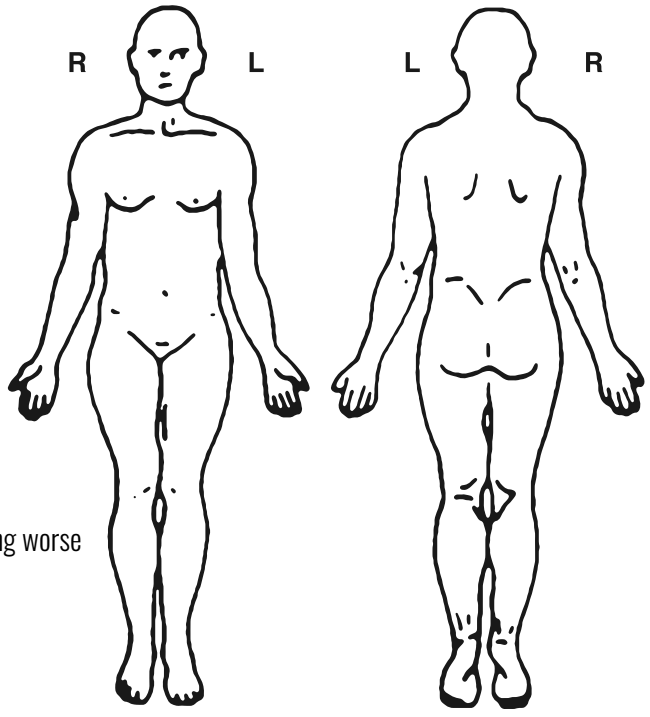
CURRENT COMPLAINTS (In order of severity)

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 makes 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 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 ❑ Cancer ❑ Tooth abcess ❑ Previous neck pain or injuries
❑ High blood pressure ❑ Diabetes ❑ Tooth extraction ❑ Previous back pain or injuries
❑ Arthritis ❑ Ulcers ❑ Tooth implant
❑ Heart disease ❑ Endometriosis ❑ Fractures_____
❑ Kidney disease ❑ Root Canal ❑ Other conditions: _____

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)

Coffee or other 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 ❑ Other: _____

FAMILY/CHILDHOOD HISTORY:

❑ Alcoholism
❑ Abuse (physical, sexual, emotional)
❑ Difficult/stressful childhood
❑ Chronic pain
❑ Chronic illness

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 ❑ Migraine headaches or other headaches
❑ Severe night pain awakening you ❑ Swelling of joints or legs ❑ Neurologic condition
❑ Unexplained fever or night sweats ❑ 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: _____