Advanced Medicine Alternatives, Ltd.

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: ____

____

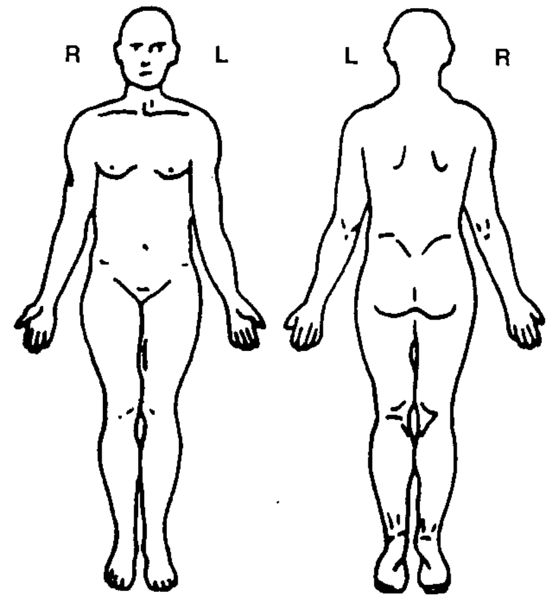
____

____

____

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)

Please rate your abilities to do the following activities (despite your pain) by circling appropriate response:

Sleep:	good	fair	poor	can't do it
Light housework:	good	fair	poor	can't do it
Heavy housework:	good	fair	poor	can't do it
Yard Work:	good	fair	poor	can't do it
Sports/recreation:	good	fair	poor	can't do it
Your regular job:	good	fair	poor	can't do it

If you can't do your regular job, please rate your ability to do

a Light duty job:	good	fair	poor	can't do it

The pain is currently: (please check) ___constant ___Intermittent ___Brief

Recently, the pain has been: ___Getting better ___Staying the same ____Getting worse

Recently, your activity tolerance 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? Freedom from all pain. Y N Doing all desired activities. Y N

(please circle) 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)

	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	Other:_____________________		Yes/No
Prolotherapy	Yes/No	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? ____No ____Yes (If so, ____/day)
Other caffeinated beverages? ____No ____Yes (If so, ____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
____ Unexplained fever or night sweats
____ Severe night pain awakening you
____ Migraine headaches or other headaches
____ Ear, nose or throat problems
____ Stomach and digestive problems/ulcers
____ Heart condition or racing heart
____ Respiratory problems
____ Kidney or urinary tract problems
____ Swelling of joints or legs
____ Neurologic condition
____ Depression or mood swings
____ Fatigue
____ Skin rashes
____ Bleeding tendencies / anemia
____ 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: ____