Name____Date________________Date first Symptoms______________
Age__________________Allergies__________________Height_______________Weight_____________________
How did you find me? ____
Medications (prescription, over the counter, anti-inflammatories, vitamins, supplements)
____
____
____
How did your current problem start? ____
Where is your pain located? ____
When do you have discomfort? constant, daily, intermittent, with rest, with activity, prolonged position, driving
____
Are you feeling better? __________ Are you moving better? __________ Can you do more? _________________
Does the pain spread to your arms or legs? ____
Do you have any pins, needles, numbness or weakness? ____
Do you "pop, crack or grind" when you move? ____
What position or activity makes you feel better? ____
What position or activity makes you feel worse? ____
When is your best time of day? _______________________ When is your worst time of day? ________________
Do you have pain with coughing or sneezing? ____
Do you have problems with your bowels or bladder? ____

Previous history of the same symptoms? ____
Previous injuries? childhood, work, sports____
Previous auto accidents? treatment, did you fully recover? ____
____

What imaging studies have you had (please circle) MRI, x-rays, CT scan, myelogram, EMG (nerve test), bone scan, discogram, arthrogram
Part of body and result? (please provide copies of reports)____

What treatment have you had? (please circle all that apply)
physical therapy. massage, home stretch, exercise, Chiropractic adjustments, Osteopathic manipulation, acupuncture, counseling, biofeedback, injections(steroid, prolotherapy, epidural, trigger point, facet, sacroiliac), surgery, Rolfing, Feldenkrais, Pilates, pool, health club, theracane, theraband, exercise ball, video tapes, orthotics, heel lifts, mouth splint, TENS unit, traction, ____

How long did you go, how many visits? ____
What helps the most? ____
How long do you get relief following therapy? ____
Do your symptoms return? ______________________ Do your symptoms improve? _________________________

Who else have you seen for this problem and when? ____
____

Do you get regular exercise? _______________________ Has this changed? ___________________________
Type? ____ How often? _______________________________
Do you smoke? _____________ How many packs per day? ________________ Years? ___________________
How much alcohol in a week? ____
Caffeine in a day? coffee, tea, pop____

Occupation? ____
Does your job involve: lifting (lbs.______), twisting, bending, climbing, push/pull, repetition, desk, computer, phone
Have you missed any work due to your current condition? ______________________________
Are you on any work restrictions? ____

Hobbies? ____
Marital status? ____________________
Are there things you have trouble doing around the house? ____________________________
Have you had essential services or help around the house? ____________________________

Can you find a position of comfort when you sleep? ________________________________
Do you sleep on your? (circle) side back stomach
Can you sleep through the night? ________________ Do you wake with pain? ________________
Do you wake feeling refreshed? ____________________
How many hours per night do you sleep? ________________
What type of pillow do you use and how many? ____________________________________
Do you put a pillow between or under your knees? ________________________________

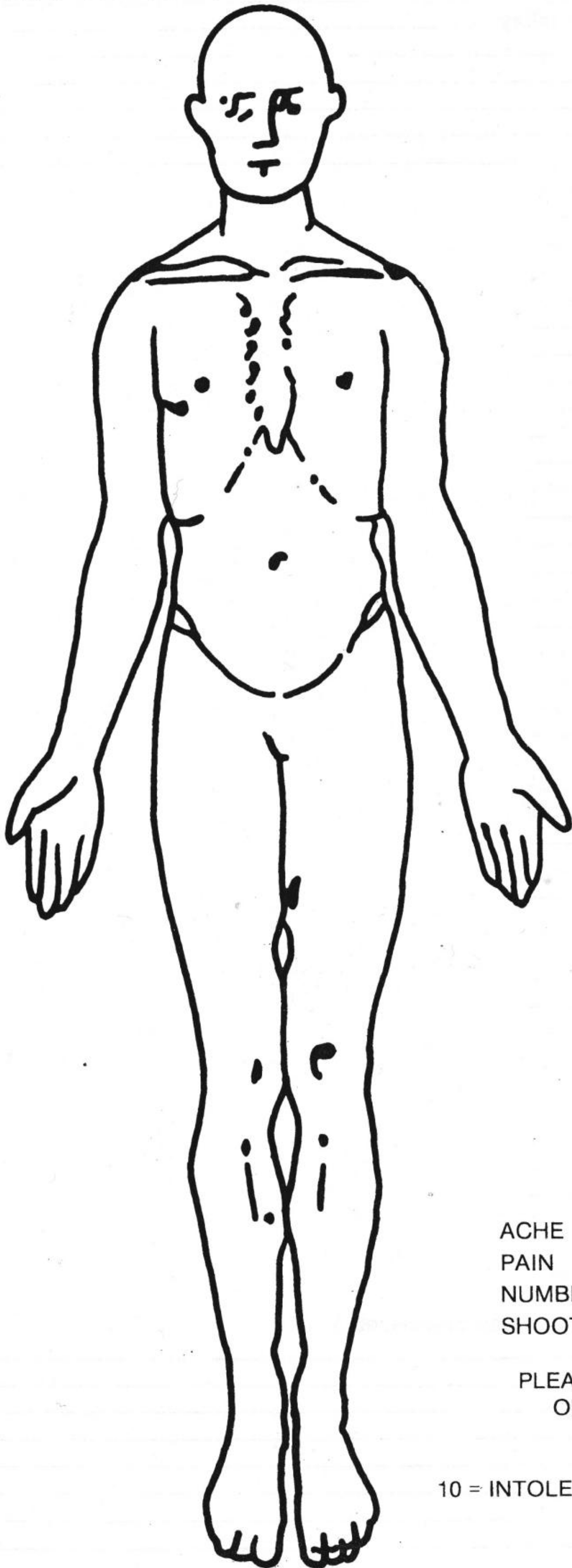
Who is your Primary Care? ____
Do you have any non-musculoskeletal medical problems? ______________________________
eyes, ears, nose, throat, heart, blood pressure, asthma, hepatitis, infectious disease, headache, skin, sleep apnea, neurological disorders, seizure, ulcers, arthritis, diabetes, thyroid, bleeding, cancer, osteoporosis
Any changes in your health history? ____
Previous surgery? ____
Family history:
Mother? ____
Father? ____
Brothers? ______________________________Sisters? ______________________________

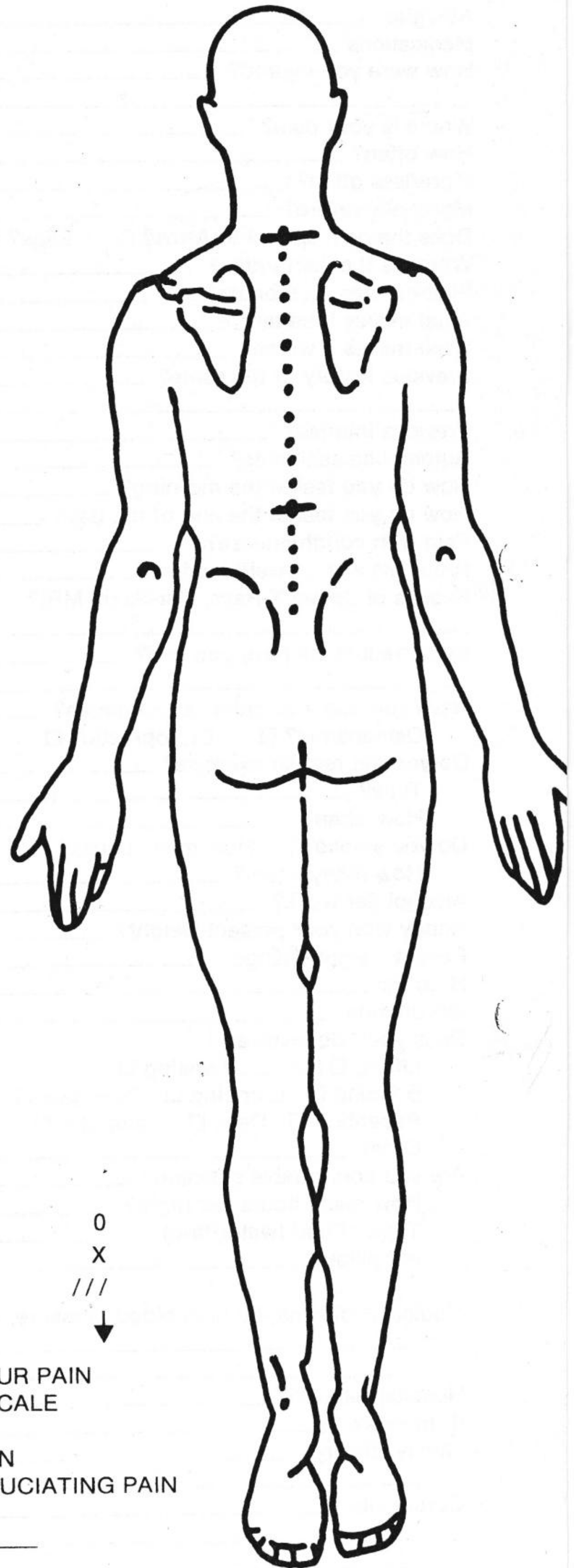
Do you have any of the following symptoms? (please circle)

Recent weight change, fever, chills, fatigue, weakness, pain down arms or legs, numbness, joint stiffness or pain, swelling, limited motion, neck or back pain, muscle cramps, night pain, deformities, scoliosis, loose joints or double-jointed, dislocations, night sweats, easy bruising or bleeding, headache, dizziness, prostate problems, tremors, unsteady gait, difficulty getting to sleep or staying asleep,
restless legs, depression.

What are your goals and expectations from your treatment?
____
____
____

DATE ____________ NAME ______________________





ACHE	0
PAIN	X
NUMBNESS	///
SHOOTING PAIN	↓

PLEASE RATE YOUR PAIN
ON A 0 — 10 SCALE

0 = NO PAIN
10 = INTOLERABLE EXCRUCIATING PAIN

average _____

at it's worst _____

OSTM-1