Name_____Date_____Date first Symptoms_____
Age_____Allergies_____Height_____Weight_____Handed:R/L
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? _____Children?_____
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? _____Mattress type, age?_____
Do you put a pillow between or under your knees? _____

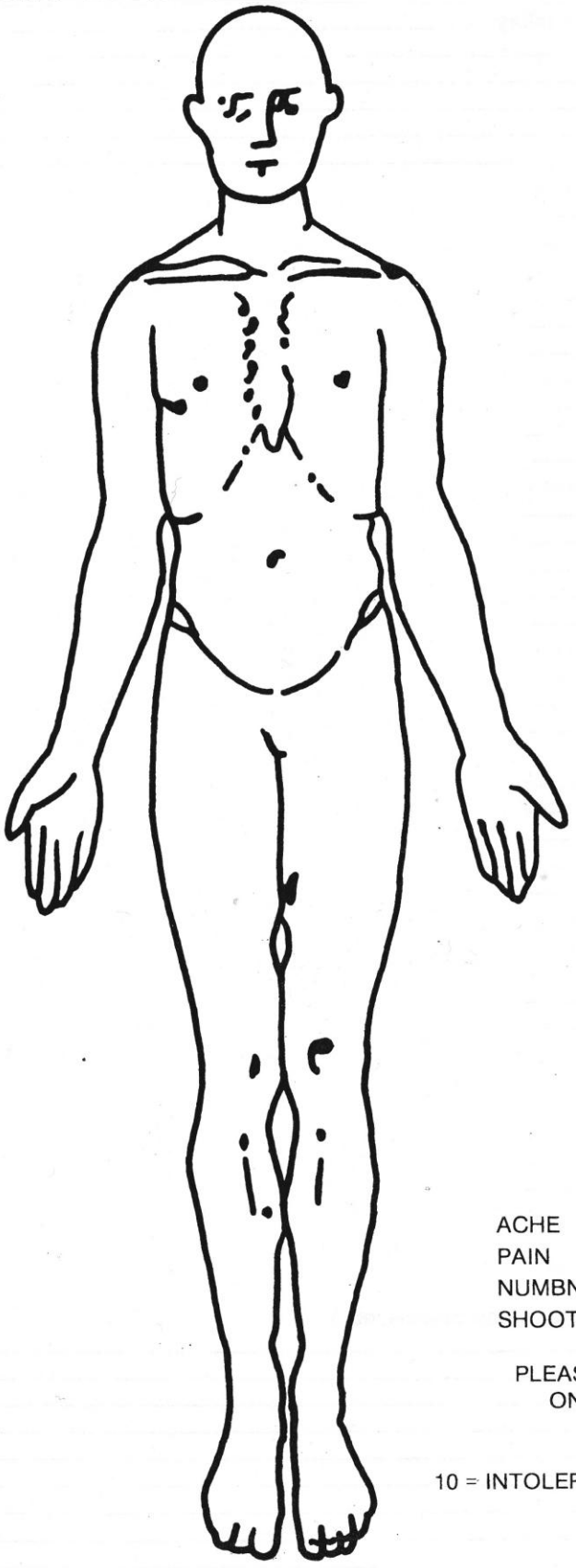
Who is your Primary Care? _____
Do you have any non-musculoskeletal medical problems? _____
eyes, ears, nose, throat, heart, blood pressure, asthma, hepatitis, infectious disease, headache, skin, sleep apnea, neurological disorders, seizure, ulcers, arthritis, diabetes, thyroid, bleeding, cancer, osteoporosis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

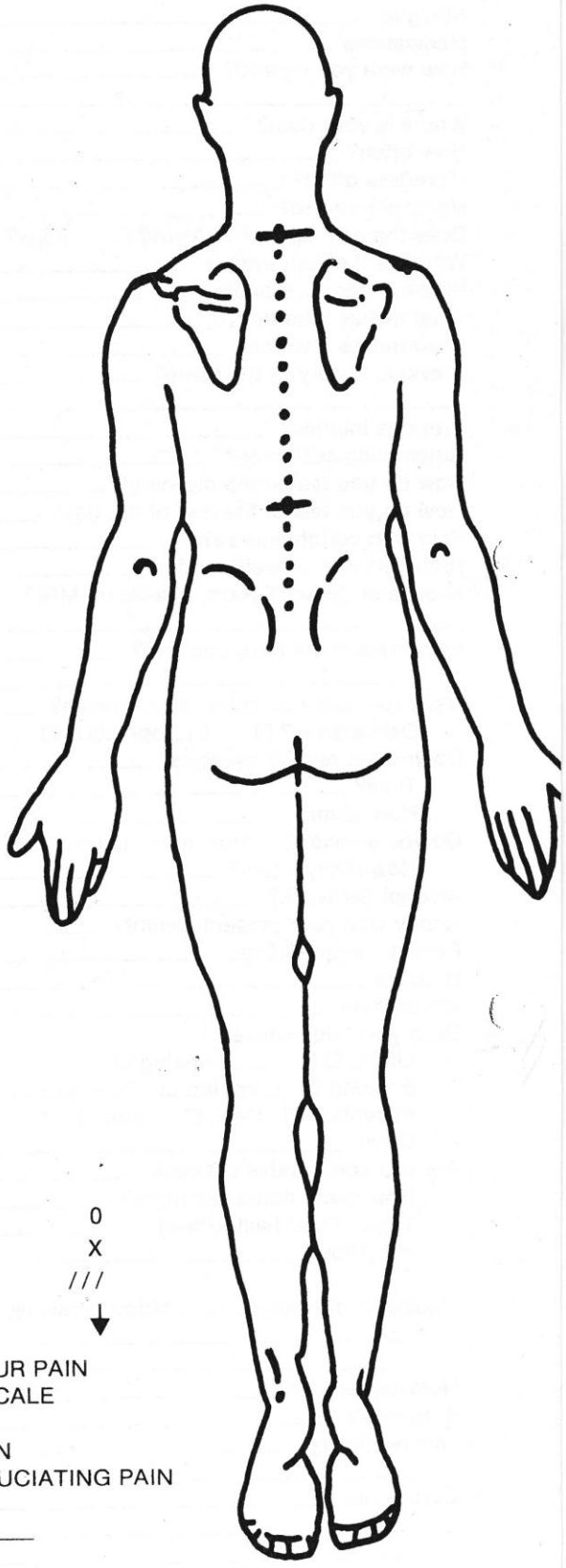
Do you have any of the following symptoms? (please circle)

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