MRM MD SPINE MEDICAL HISTORY

Name: _____

Age: _____

Referred By : _____

Where are you experiencing your pain ? (Check all that apply)

[ ] **Back**
[ ] **Neck**

[ ] Hip [ ] Thigh [ ] Knee [ ] Lower Leg [ ] Ankle/Foot
[ ] Shoulder [ ] Upper Arm [ ] Elbow [ ] Forearm [ ] Wrist/Hand

HISTORY OF ONSET

When did this current episode of pain / your problem begin? _____

Did the pain / problem begin: [ ] gradually [ ] suddenly

How did this episode of pain begin?

[ ] Bending [ ] Twisting [ ] Pushing / Pulling
[ ] Lifting [ ] Fall [ ] Motor vehicle Accident
[ ] _____

If your pain is due to an injury, briefly describe the events that led to the injury.

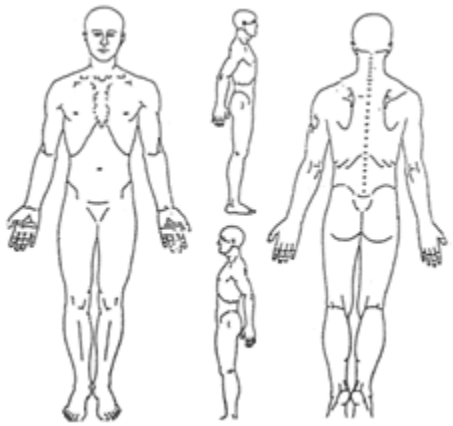
_____
_____
_____

Have you had prior episodes of this pain / problem? [ ] Yes [ ] No

If yes, how many episodes have you had?
When did the first episode begin?
Is this episode worse than previous episodes? [ ] Yes [ ] No
Do the episodes occur more readily and last longer? [ ] Yes [ ] No
Explain what caused the prior episodes.

Use the diagram and symbols to indicate where your pain is.

Ache: AAA Burning:XXX Numbness:OOO Pins/Needles: …… Stabbing://///



If your pain is due to an injury, briefly describe the events that led to the injury.

_____

_____

_____

If you have back pain *with* leg pain or neck pain with arm pain, please answer the following :

*Do you ever have your back or neck pain ***without*** your leg / arm pain? [ ] Yes [ ] No

*Which statement best describes the ratio between your back/neck pain and leg/arm pain.

[ ] 90% back or neck pain and 10% leg or arm pain
[ ] 75% back or neck pain and 25% leg or arm pain
[ ] 50% back or neck pain and 50% leg or arm pain
[ ] 25% back or neck pain and 75% leg or arm pain
[ ] 10% back or neck pain and 90% leg or arm pain

Please check the activities that affect the pain or your problem.

	Better	Worse	No Change		Better	Worse	No Change
Coughing / Sneezing	[ ]	[ ]	[ ]	Bending Forward	[ ]	[ ]	[ ]
Straining	[ ]	[ ]	[ ]	Bending Backward	[ ]	[ ]	[ ]
Standing	[ ]	[ ]	[ ]	Lying on Back	[ ]	[ ]	[ ]
Walking	[ ]	[ ]	[ ]	Lying on Stomach	[ ]	[ ]	[ ]
Sitting	[ ]	[ ]	[ ]	Overhead Reaching	[ ]	[ ]	[ ]
Lifting	[ ]	[ ]	[ ]	Squatting	[ ]	[ ]	[ ]
Pushing/ Pulling	[ ]	[ ]	[ ]	Kneeling	[ ]	[ ]	[ ]
Driving	[ ]	[ ]	[ ]	Typing / Writing	[ ]	[ ]	[ ]
During Activity	[ ]	[ ]	[ ]	After Activity	[ ]	[ ]	[ ]

*** Please circle the number that best represents your *average* pain.**

What is the LEAST?	0	1	2	3	4	5	6	7	8	9	10
What is the MOST?	0	1	2	3	4	5	6	7	8	9	10
What is it TODAY?	0	1	2	3	4	5	6	7	8	9	10

TREATMENT HISTORY

List the physicians and chiropractors that you have seen for your pain / problem

Doctor's Name Specialty Location Approx. Date.

_____
_____
_____
_____

Which of the following tests or treatments have been done for your pain / problem.

	No	Yes	Date What Area of Body /Results
X-Rays	[ ]	[ ]	_____
Bone Scan	[ ]	[ ]	_____
MRI	[ ]	[ ]	_____
CT Scan	[ ]	[ ]	_____
Myelogram	[ ]	[ ]	_____
EMG / NCS	[ ]	[ ]	_____
Discogram	[ ]	[ ]	_____
Epidural Steroid Injection	[ ]	[ ]	_____
Nerve Root Block	[ ]	[ ]	_____
Facet Joint Injection	[ ]	[ ]	_____
Sacroiliac Joint Injection	[ ]	[ ]	_____
Other	[ ]	[ ]	_____

If you had surgery for this or a similar problem, complete the following for each operation.

Surgery	Date	Worse	Same	Better
_____		[ ]	[ ]	[ ]
_____		[ ]	[ ]	[ ]
_____		[ ]	[ ]	[ ]

PRIOR TREATMENT

If you have had physical therapy / chiropractic in the past, please indicate where, when and how long you attended.

_____

Please place a check next to the type of treatment you received and how it affected your pain/problem.

	Yes	Helped	No Effect	Made Worse
Physical Therapy	[ ]	[ ]	[ ]	[ ]

Massage / MFR / CSR	[ ]	[ ]	[ ]	[ ]
Chiropractic / Adjustments	[ ]	[ ]	[ ]	[ ]
Acupuncture	[ ]	[ ]	[ ]	[ ]
Other _____	[ ]	[ ]	[ ]	[ ]

Which helped the MOST? _____

Which helped the LEAST? _____

Are you currently receiving any of the aforementioned treatments now? [ ]Yes [ ]No

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LIFESTYLE HISTORY

How many caffeinated beverages do you drink per day / week? _____ per day / week

Do you smoke? [ ] No [ ] Yes

If Yes, how many cigarettes do you smoke per day / week? _____ per day / week

If you quit, how long did you smoke and when did you quit? _____

How many alcoholic beverages do you drink per day / week? _____ per day / week

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