1395 East Eldorado Pkwy
Suite # 200
Little Elm, TX 75068
Phone: 972-987-4672
Fax: 972-987-4693
admins@littleelmprc.com

Patient Name: _____ Date: _____

DOB:_____ Referring Physician:_____

1. **When did your symptoms start?** _____
2. **Describe your symptoms:**_____

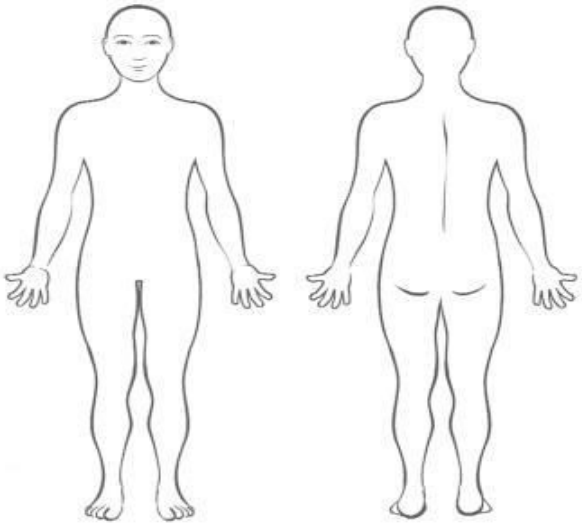
_____

3. **What is your goal for therapy?**_____

_____

4. **How often do you experience your symptoms?** (Check one below)

❑ Constantly (76%-100% of the day) ❑ Frequently (51%-75% of the day)
❑ Occasionally (26%-50% of the day) ❑ Intermittently (0%-25% of the day)



5. **Mark your areas of pain or discomfort based on the chart below**:

Sharp pain △ △ △ △ △
Shooting pain ××××××
Dull Ache □□□□□
Burning pain ○○○○○
Numbness and Tingling ⋀⋀⋀⋀⋀
Stabbing pain ⊗⊗⊗⊗⊗

6. **How are your symptoms changing?** (Check one below)

❑ Getting better ❑ Not changing ❑ Getting worse

7. **Your symptoms are worse in the**: (Check all that apply)

❑ Morning ❑ Increased during the day ❑ Afternoon ❑ Night ❑ Same all day

8. **What movement causes the pain to increase?**

❑ Sitting ❑ Standing ❑ Bending ❑ Reaching ❑ Stepping ❑ Pushing ❑ Pulling

9. **How much has it interfered with your normal work (including home and housework)?** (Check one below)

❑ None of the time ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

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10. During the past 4 weeks: (Circle to indicate)

Indicate the intensity of pain AT REST :

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

Indicate the intensity of pain WITH MOVEMENT:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

11. What makes your problem better? (Check all that apply)

❑ Nothing ❑ Standing ❑ Movement/Exercise ❑ Lying Down ❑ Sitting ❑ Inactivity
❑ Heat ❑ Ice pack

12. What makes your problem worse? (Check all that apply)

❑ Nothing ❑ Standing ❑ Movement/Exercise ❑ Lying Down ❑ Sitting ❑ Inactivity

13. During the past 4 weeks how much of the time has your condition interfered with your social activities? (Example: visiting with friends, relatives, etc.) (Check one below)

❑ All the time ❑ Most of the time ❑ Some of the time ❑ A little of the time ❑ None of the time

14. In general would you say your overall health right now is... (Check one below)

❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

15. Who have you seen for your symptoms? (Check one below)

❑ No One ❑Chiropractor ❑ Medical Doctor ❑Physical Therapist
❑ Other _____

16. What tests have you had for your symptoms and when were they performed?

(Check one) ❑ X-rays date: _____ ❑ CT Scan date: _____ ❑ MRI date: _____
Did you have surgery? ❑ Yes ❑ No Date of Surgery if applicable: ___/___/___

17. Have you had similar symptoms in the past? ❑ Yes ❑ No

18. What is your occupation? _____

19. Please check off if you have had any of the conditions listed below:

❑ High blood pressure ❑ Angina ❑ Diabetes ❑ Heart attack ❑ Cancer/Tumor
❑ Rheumatoid Arthritis ❑ Epilepsy ❑ Arthritis ❑ Stroke ❑ Systemic Lupus
❑ Asthma ❑ Pregnancy ❑ HIV/AIDS ❑ Tobacco packs/day ❑ Hepatitis ❑ Osteoporosis

20. Medications: _____

Patient Signature: _____ **Date:** _____