

# Patient Application for Care

## P a t i e n t I n f o r m a t i o n

Name: (First, Last)		Today's Date:		Birth Date: (Mo/day/Yr)	
Street Address:			City:	State:	Zip Code:
Height: _____ Ft _____ In	Weight:	SSN:	E-mail Address:		Home Phone:
Place of Employment:		Job Description:		Work Phone:	
Marital Status:		Spouse Name:		Spouse Employer:	

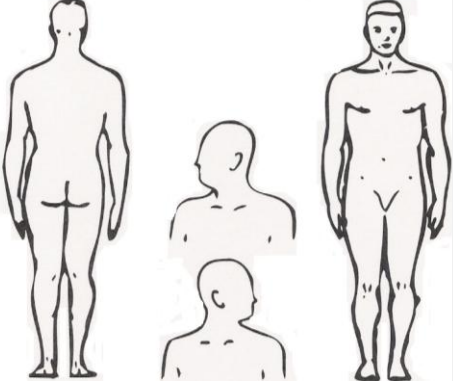
## W h a t B r o u g h t Y o u i n T o d a y

What problems or symptoms motivated you to visit us today...please explain:

In spite of the fact that you are not a back specialist, you are in fact the person who knows more about your back than anyone else. In your own words and in your own opinion what do you think the real problem is?

Since your pain became this severe what **3** things has it caused you to miss the most?

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

<p><b>Please mark the areas of pain on the figures below.</b></p> 	How long has your problem been like this?	What activities are you limited in?
	How has your life changed since your back became a problem?	
	What kinds of treatments have you received?	
	Physical Therapy-How Long _____ When (approx) _____	Medication _____ When (approx) _____
Surgery-Type _____ When (approx) _____	Other _____	
Did any of these treatments work? If so which one(s)? For how long?	Have you become tolerant to the pain? Yes No	

What activities/movements are guaranteed to make it worse?	Is there anything that you do that makes it better?	Is it worse in the morning or is it worse as the day progresses?
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On a Scale 1-10, (1= Mild & 10 = Very Bad) Where would you rank your discomfort <b>RIGHT NOW?</b>	Where would you rank your discomfort <b>ON AVERAGE?</b>	Where would you rank your discomfort <b>AT IT'S WORST?</b>
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

Please circle the **one** option below that best describes **how often** you have pain.

1. All of the time    2. Most of the time    3. A good bit of the time    4. Some of the time    5. A little of the time

6. Hardly any of the time    7. None of the time

