Fort Wayne
Physical Medicine
A Conservative Nonsurgical Approach for Effective Pain and Injury Treatment

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NAME: _____ DATE: _____

Age: _____ Dominant Hand: R L Sex: F M Height: _____ Weight: _____

Who referred you to Dr. Reecer? _____

1. Please describe your main symptom: _____
_____

2. Was the onset of symptoms: (Please circle) Gradual Sudden

3. Date of onset of present symptoms: _____

4. Are your symptoms due to an injury? NO YES
If yes, please describe:
_____
_____

5. Is this injury work related? NO YES UNSURE

6. Have you had prior injuries/problems similar to your current condition? NO YES
If yes, please explain:

CAUSE OF INJURY	DATE	TREATMENT	WEEKS OFF WORK
_____	_____	_____	_____
_____	_____	_____	_____

7. Are the symptoms now worse, better or the same compared to when they began? _____

8. Do you presently have pain? NO YES
Is the pain CONSTANT INTERMITTENT
Location _____

9. Do you presently have numbness? NO YES
Is the numbness CONSTANT INTERMITTENT
Location _____

10. Do you presently have tingling? NO YES
Is the tingling CONSTANT INTERMITTENT
Location _____

11. Do you presently have weakness in the arms and/or legs? NO YES
Is the weakness CONSTANT INTERMITTENT
Location _____

12. Have you noticed changes in urination? NO YES
Which: Increased frequency Inability to hold urine
Dribbling after voiding Difficulty passing urine

13. Have you noticed changes with your bowels? NO YES
Which: Constipation Diarrhea Loss of control

14. Check how each of the following activities affects your pain.

	Aggravates Pain	No Change	Relieves Pain
Sitting	_____	_____	_____
Standing	_____	_____	_____
Leaning forward	_____	_____	_____
Walking	_____	_____	_____
Lying on your side	_____	_____	_____
Lying on your back	_____	_____	_____
Lying on your stomach	_____	_____	_____
Driving	_____	_____	_____
Coughing/Sneezing	_____	_____	_____

****Please circle the most aggravating activity and underline the most relieving activity.**

15. Do the symptoms wake you up at night? NO YES

16. Do the symptoms keep you from participating in activities that you enjoy? NO YES
Which activities? _____

17. Which of the following studies have you had done?

	Date and Location
O Regular X-rays	_____
O CT Scan	_____
O MRI Scan	_____
O EMG	_____
O Discogram	_____
O Bone Scan	_____

18. Treatment – Please check the appropriate columns.

		Helpful	Not Helpful	Worse	# of Treatments
Physical Therapy	(NO or YES)	_____	_____	_____	_____
Exercise on your own	(NO or YES)	_____	_____	_____	_____
Chiropractic Adjustment	(NO or YES)	_____	_____	_____	_____
Epidural Injection	(NO or YES)	_____	_____	_____	_____
TENS Unit	(NO or YES)	_____	_____	_____	_____
Other Treatment _____		_____	_____	_____	_____

19. List all physicians and chiropractors you have consulted for your present condition:
_____

20. Please circle any of the following problems that **<u>you</u>** have had:

Diabetes	Pacemaker	Heart Attack	Hepatitis
Coronary Artery Disease/Angina	Asthma	Blood disorders	Arthritis
Heart valve disease	Emphysema	High blood pressure	Stroke
Blood vessel disease	Tuberculosis	Bleeding tendencies	Glaucoma
Kidney infections	Seizure	Skin disorders	Kidney stones
Neurological disorders	Blood clots	Cancer/tumors	Kidney disease
Ulcers of stomach or bowel	Liver disease	Thyroid disease	HIV/AIDS

Other: _____

Past Surgical History

21. Please list all previous surgeries

Surgery_____ Date_____
Surgery_____ Date_____
Surgery_____ Date_____
Surgery_____ Date_____

22. Medications: Are you allergic to iodine, dye or shellfish? NO YES

Do you have any allergies to medications? NO YES If yes, which ones? _____

Which medications are you using for your current complaints? (Include the amount and strength)

_____ _____ _____
_____ _____ _____

What medications did you previously use for your current complaints?

_____ _____ _____
_____ _____ _____

What medications are you taking for other problems?

_____ _____ _____
_____ _____ _____

23. Review of systems

Please circle any of the following problems that you **currently** have.

Fevers	Chills	Blood in your urine
Night sweats	Unexplained weight loss	Bloody or dark stools
Swelling	Headaches	Chest pain
Problem with balance	Problems with coordination	Shortness of breath
Double vision	Blurred vision	Coughing
Fainting	Dizziness	Abdominal pain
Difficulty swallowing	Difficulty with speech	Change in appetite

24. Are you or could you be pregnant? NO YES

25. Family History: List any family medical problems_____

26. Social History:

a) Please circle Single Married Divorced Widow/Widower
If married, age and health of spouse: Age_____ Health _____

b) Education: What was the last school grade you completed:
_____?
List other degrees: _____

c) Number of children _____ Ages: _____

d) Habits:

Drug use	No _____	Yes _____		
Alcohol use	No _____	Yes _____	drinks per day _____	
Tobacco use	No _____	Yes _____	packs per day _____	

27. Occupational History

Name of Employer _____ How Long? _____

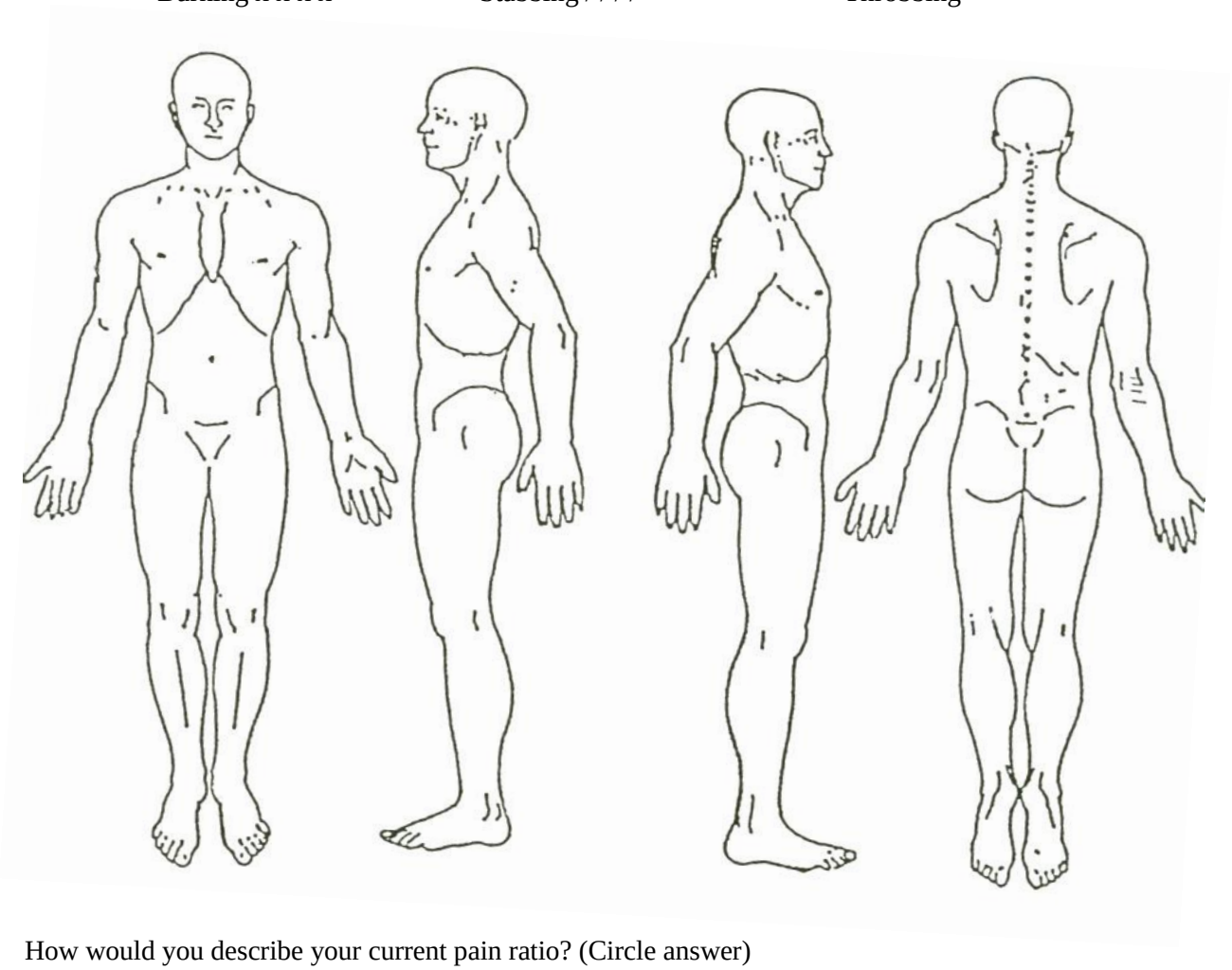
Occupation _____ Date you last worked _____

How many hours of your usual workday do you spend:

Sitting ____ Standing ____ Walking ____ Driving ____ Lifting ____ How heavy? _____

28. Mark the areas on your body where you feel your pain. Include all affected areas. Use the appropriate symbol as indicated below:

Ache >>>>	Numbness = = = =	Pins and Needles o o o o
Burning x x x x	Stabbing / / / /	Throbbing ++++



How would you describe your current pain ratio? (Circle answer)

1. 100% back pain, 0% leg pain
2. 75% back pain, 25% leg pain
3. 50% back pain, 50% leg pain
4. 25% back pain, 75% leg pain
5. 0% back pain, 100% leg pain
6. 100% neck pain, 0% arm pain
7. 75% neck pain, 25% arm pain
8. 50% neck pain, 50% arm pain
9. 25% neck pain, 75% arm pain
10. 0% neck pain, 100% arm pain

Current Pain Intensity: Please circle which best describes your current pain level.
0 represents no pain - 10 is the worst pain you can imagine

0 1 2 3 4 5 6 7 8 9 10