

ROANOKE BACK PAIN RELIEF & REHABILITATION CENTER

INITIAL PATIENT CONSULTATION FORM

PATIENT INFORMATION:

Name:	Today's Date:
Address:	Phone:
Email:	Birth Date:

RECENT OR CURRENT SYMPTOMS

SYMPTOM	HOW LONG?	SYMPTOM	HOW LONG?
<input type="checkbox"/> Headaches/Migraines		<input type="checkbox"/> Upper Back Pain, Soreness, or Stiffness	
<input type="checkbox"/> Neck Pain, Soreness, or Stiffness		<input type="checkbox"/> Hip Pain	
<input type="checkbox"/> Low Back Pain, Soreness, Stiffness		<input type="checkbox"/> Leg or Foot Pain, Numbness, or Tingling	
<input type="checkbox"/> Arm/Hand Pain, Numbness, or Tingling		<input type="checkbox"/> Other	

How intense is your typical neck, mid back, low back pain or both?

Pain Intensity	None	Mild Discomfort/Ache/Stiff			Moderate Hurts/Sore/Bearable Sensation				Severe Sharp/Intense Pain		
	0	1	2	3	4	5	6	7	8	9	10
Pain: _____											

WHAT IS YOUR MAJOR COMPLAINT?

DESCRIBE: _____

HAVE YOU HAD THIS PROBLEM LONGER THAN A WEEK OR TWO? YES NO
 HOW LONG? _____

HAVE YOU HAD THIS PROBLEM MORE THAN 2 OR 3 TIMES? YES NO

BEFORE YOU BEGAN HAVING THIS PROBLEM, WAS THERE AN EARLIER ACCIDENT OR INJURY THAT COULD HAVE BROUGHT THIS ABOUT OR BE RELATED TO IT? YES NO
 IF SO, PLEASE DESCRIBE: _____

WHAT HAVE YOU TRIED TO GET RID OF THE PROBLEM THAT DID NOT WORK? (Exercises, Massage, Magnets, Laser, Injections, Medication, Etc.) _____

HAVE YOU SEEN A CHIROPRACTOR, P.T., OR M.D. FOR THIS PROBLEM? YES NO
 If yes, Doctor's Name: _____ Year: _____
 Problem seen for: _____
 If yes, Doctor's Name: _____ Year: _____
 Problem seen for: _____

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HOW DOES THIS PROBLEM MAKE YOU FEEL PHYSICALLY OR EMOTIONALLY WHEN IT IS AT ITS WORST? (i.e. does it create stress for you?) _____

WHAT MAKES YOUR PAIN WORSE? _____

- | | | |
|---|--|--|
| <input type="checkbox"/> Morning | <input type="checkbox"/> Evening | <input type="checkbox"/> Walking over hard surfaces |
| <input type="checkbox"/> While sleeping | <input type="checkbox"/> Lying down | <input type="checkbox"/> Standing > _____ minutes |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Sitting | <input type="checkbox"/> Bending/Leaning/Twisting |
| <input type="checkbox"/> Stress (mental) | <input type="checkbox"/> Bad posture | <input type="checkbox"/> Exercise/Stretching/Hobbies |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Medical Treatment/Injection | <input type="checkbox"/> When I go to physical therapy |
| <input type="checkbox"/> When I do sports _____ | <input type="checkbox"/> When I do my rehab exercise | <input type="checkbox"/> When I cough or sneeze |

HOW DOES THIS PROBLEM INTERFERE WITH YOUR ABILITY TO WORK? _____

HOW DOES THIS PROBLEM INTERFERE WITH YOUR FAMILY & SOCIAL LIFE?

HOW DOES THIS PROBLEM INTERFERE WITH YOUR ABILITY TO DO RECREATIONAL ACTIVITIES, HOBBIES or SPORTS? _____

DOES THIS PROBLEM MAKE YOU FEEL OLDER THAN YOU ARE? YES NO

IF YES, PLEASE DESCRIBE: _____

HAVE YOU BEEN WORRIED ABOUT GETTING THIS PROBLEM RESOLVED? YES NO

IF YES, PLEASE DESCRIBE: _____

IF UNHANDLED, HOW WOULD THIS PROBLEM AFFECT YOU? _____

ON A SCALE FROM 1 TO 10 WITH 10 BEING THE HIGHEST, WHAT IS YOUR INTEREST IN GETTING HELP TO GET RID OF THIS PROBLEM?

INTEREST SCALE: _____	0	1	2	3	4	5	6	7	8	9	10
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COMMENTS/QUESTIONS: _____

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