Today's Date: _____

New Problem

Name: _____ **DOB:** _____ **Height:** _____ **Weight:** _____

Current Condition (You must complete all questions below as they may be required in order to obtain authorization from your insurance company for continued treatment(s).)

Reason For Visit Today (Briefly Describe Condition): _____

_____

_____

Please specify which side: Left Right Both

How would you describe your pain? (Circle all that apply): Throbbing Dull Shooting Weak

Stabbing Achy Sharp Difficult to Describe Numbness Tingling Popping Buckling

Swelling Locking Grinding Giving Way Discharge Discoloration Worse at Night

Severity of symptoms (Circle One): Mild Moderate Severe

Pain Scale 0-10: _____

Timing (Circle One): Constant Intermittent Varies with Activities

At most, how LONG can you walk without difficulty?

Cannot Walk < 5 Mins. <15 Mins. <30 Mins <60 Mins No Limit

At most, how FAR can you walk without difficulty?

Cannot Walk Unable to Walk Through Grocery Store No Limit

<1/4 Mile (2 Blocks) <1 Mile <5 Miles

How long ago did the problem start? _____

Were you seen in the ER? (Circle One): Yes No If yes, which ER? _____

Was there an injury? (Circle One): Yes No If yes, explain: _____

_____

Any imaging in the past 6 months for this issue? (X-Rays, MRI, CT, Etc.) (Circle One): Yes No

If yes, where was this done? (Banner Imaging, SimonMed, etc.) : _____

We are only able to retrieve actual images from SimonMed, SMIL, and certain Arizona Diagnostic Radiology locations. If you have had imaging performed at a different imaging facility, please bring a copy of imaging along with you to your appointment.

Do you have difficulty getting dressed (socks, shoes, pants, etc.)? (Circle One): Yes No

Do you have difficulty performing tasks at work or around the house? (Circle One): Yes No

If yes, explain: _____

New Problem

Do any of the following improve or worsen your symptoms? (Circle One for Each)

Ace Wrap	Improves	Worsens	Has No Affect	Does Not Apply
Bracing	Improves	Worsens	Has No Affect	Does Not Apply
Cold	Improves	Worsens	Has No Affect	Does Not Apply
Elevation	Improves	Worsens	Has No Affect	Does Not Apply
Heat	Improves	Worsens	Has No Affect	Does Not Apply
Kneeling	Improves	Worsens	Has No Affect	Does Not Apply
Lying Down	Improves	Worsens	Has No Affect	Does Not Apply
Running	Improves	Worsens	Has No Affect	Does Not Apply
Squatting	Improves	Worsens	Has No Affect	Does Not Apply
Stairs	Improves	Worsens	Has No Affect	Does Not Apply
Standing	Improves	Worsens	Has No Affect	Does Not Apply
Throwing	Improves	Worsens	Has No Affect	Does Not Apply
Walking	Improves	Worsens	Has No Affect	Does Not Apply
Other:_____	Improves	Worsens	Has No Affect	Does Not Apply

Please indicate any interventions you have tried and if they have made the issue better or worse:

Activity Modification

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name):_____

NSAIDs (Aleve, Ibuprofen, Diclofenac, Meloxicam, etc.)

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name):_____

Assistive Devices (Cane, Walker, Etc.)

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name):_____

New Problem

Please indicate any interventions you have tried and if they have made the issue better or worse:

Chiropractic

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name):_____

Home Exercises

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name):_____

OTC Meds- Herbal/Homeopathic/Supplements

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name):_____

Other Injections (Hyaluronic Acid, Etc.)

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name):_____

Physical Therapy

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name):_____

Steroid Injections (Cortisone)

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name):_____

Other: _____

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name):_____