David M. McKalip, MD, LLC
Patient History *Neck/Back/Extremity Pain*

Name: _____ Date: _____ Age _____

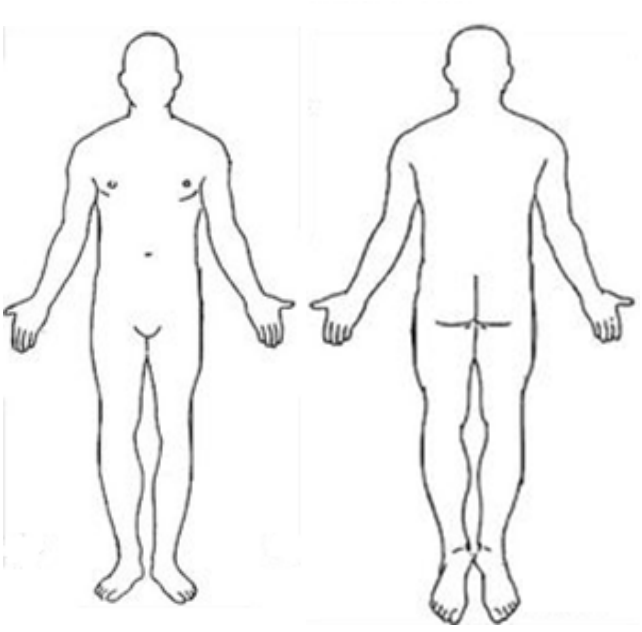
Date of Birth: _____ Biological Sex: Male____ Female____ | Right ____or Left ___Handed

Chief Complaint - problem(s) for which you are here today:

__Neck pain __Arm pain (__Left __Right)
__Back pain __Leg pain (__Left __Right)
Other: _____

_____

Please shade in the area(s) on the diagram where you have **pain**:



Front Back
R L L R

Severity: __Mild __Moderate __Severe __Extreme

Frequency: __Rare __Occasional __Often __Always

Duration: __Days __Weeks __Months __Years

Date of first pain? _____

Where were you when pain began?
__Home __Work __Auto Accident
__Other_____

Associated symptoms (place "X" in appropriate box):

	Left Arm	Right Arm	Left Leg	Right Leg
Numbness				
Tingling				
Burning				
Weakness				
Other				

Timing: _____
Does pain/problem occur at any specific time?

Have you ever had same problem before? __Yes __No. If yes, when/where:

_____

_____

Modifying Factors:
Place an "X" in box next to situation that increase or decreases your pain.

Makes pain <u>better</u>	**Makes pain <u>worse</u>**	**No effect**	
			Sitting
			Standing
			Lying down
			Coughing/sneezing/straining
			Heavy Lifting
			Bending/twisting (Neck__ Back___)
			Walking (Distance_____)
			Medications
			Other

Indicate if you have tried to relieve your pain with any of the following.

Therapy	**<u>Pain Relief (check box)</u>**			**<u>When (how long ago?)</u>**			
	None	**Some**	**Total**	**Ongoing**	**Weeks**	**Months**	**Years**
__ Acupuncture							
__ Braces							
__ Chiropractic Manipulation							
__ Electrical Stimulation							
__ Massage							
__ Muscle Injections							
__ Spine Injections							
__ Physical Therapy							

Have you seen other doctors or had surgery for this problem before? (please indicate doctor and date)

Doctor	Approximate Date

Other Information: _____
_____
_____
_____
_____

Past Medical History: Please indicate if you have or have had any of the following illnesses:

Heart Disease	Lung Disease	Cancer	Other
__Heart Attack __Angina __Rheumatic Fever __Valve disease __Irregular heart beat __High Blood Pressure	__Emphysema __Pneumonia __Asthma __Bronchitis	__Breast __Prostate __Lung __Skin Other_____	__Diabetes __Kidney Disease __Skin Disease __Liver disease (Hepatitis, cirrhosis etc…) __Sexually transmitted Disease __Psychiatric diagnosis (bipolar disorder, schizophrenia, depression etc….)

Please list any other medical problems or relevant details of above:

_____
_____
_____
_____

Surgical History: Please list any prior surgeries, along with dates, surgeon, city and hospital if available.

Operation	Date/Surgeon/City/Hospital

Prescriptions:

Medication	Strength (dose)	Amount / Frequency

Non-prescription remedies/medications you take regularly:

_____

_____

_____

Allergies:_____

_____

_____

Social History:

Town/location of Permanent Residence: _____ ___Seasonal Resident
Occupation:_____ __Retired
Company:_____
Primary Care Doctor_____
Employed now? __Y __N __on sick/disabled leave. Approximate date ceased employment_____
Work related Injury ___Y ___N Approximate Date of Injury:_____
Pain onset related to an injury? __Y___N Approximate Date:_____
Workman's compensation case? ___Y____N
Legal case pending relating to your illness/injury?__Y___N. Attorney:_____
Applying for ___or receiving ____disability income related to this injury/illness? ___Y ____N

Substance	**Daily amount**	**Number of years**	**Marital Status:** Single ____ Married ____ Widowed ____ Separated ____ Divorced ____
___Tobacco			
___Alcohol			
___Recreational Drugs (list please)			**Number of Children:** ____

Family History: Please list any medical conditions or illness that are present in your family.

Other/Details of items indicated above:

Review of Systems: Please indicate if you currently or regulary are experiencing any of the following if not already described. (Check if "yes", otherwise will assume "no"):

Constitutional
__General Good Health Lately
__Fever
__Weight Loss
__Weight Gain

Hematologic
__Bleeding Gums
__Easy Bruising
__Tendency to bleed easily

Pulmonary/Cardiac
__Chest Pain
__Irregular heart beat
__New or persistent cough
__Productive cough
__Bloody cough
__Wheezing
__Shortness of breath

Endocrine
__Excessive Thirst
__Excessive Urination

Musculoskeletal
__Joint Pain
__Muscle wasting

Ears/Nose/Throat
__Nasal discharge or postnasal drip
__Nasal bleeding
__Bleeding gums
__Tooth infections

Skin
__New moles/skin abnormalities
__Rash
__Open sores
__Skin Growth

Gastrointestinal/ Genitourinary
__Stomach/Abdominal Pain
__ Indigestion
__Diarrhea
__Constipation
__Blood in stool
__Blood in urine
__Foul Smelling urine
__Rising from sleep to urinate

Psychiatry/Other
__Hallucinations
__Depression
__Hearing Voices
__Anxiety
__Claustrophobia

Neurologic
__Loss of speech/poor speech/poor understanding of speech
__Confusion
__Poor memory
__Headache
__Change or loss of smell/taste
__Loss of vision/poor vision __L__R
__Double vision
__Blind spots __L__R
__Visual flashing __L__R
__Facial pain/numbness or weakness __L__R
__Loss of hearing/poor hearing __L__R
__Ringing in ears __L__R
__Difficulty swallowing

__Arm Pain/numbness/tingling __L__R
__Leg Pain or numbness __L__R
__Neck Pain
__Back Pain
__Other Pain or numbness
__Arm Weakness __L__R
__Leg Weakness __L__R
__Loss of Bladder or Bowel control
__Poor Sexual function
__Difficulty Walking
__Loss of coordination

Other/Details of items indicated above: