Name: _____

Date of Birth: _____

PREMIER
Bone & Joint Centers
A Registered Trade Name of Gem City Bone & Joint, P.C.
Phone: (307) 745-8851 / Fax: (307) 721-9926

HISTORY FORM

Dr. Kaplan looks forward to your visit. To help assure that your records are complete and that you are provided with the highest quality of care possible, please complete ALL 4 PAGES in this Questionnaire and bring them with you to your appointment as well as any additional paperwork which may be provided.

HISTORY OF PRESENT ILLNESS:

What specific symptoms and region of your body were you referred for treatment / evaluation?

_____

What day did your pain begin? _____ Was it gradual or sudden onset? _____

How did it occur? _____

What doctors (name & location) have you seen for this injury, if any, or who referred you for this evaluation?

_____

Are your symptoms the result of a work related injury (Workers' Comp)? ☐ Yes ☐ No
A motor vehicle accident? ☐ Yes ☐ No If injured, is there a law suit? ☐ Yes ☐ No

Have your symptoms changed since they first began? If so, how? _____

_____

Dominant Hand ☐ Right ☐ Left

Currently, do you have trouble sleeping at night because of your pain? ☐ Yes ☐ No

Check the following that apply (describe) your problem / pain.

☐ Constant	☐ Intermittent	☐ Burning	☐ Sharp	☐ Electrical
☐ Aching	☐ Muscle Spasms	☐ Skin Sensitivity	☐ Tingling/Numbness	

Does your pain radiate (travel from place to place)? ☐ Yes ☐ No If yes, from where to where?

_____

Please check the box which closest describes the ratio between pain in your back and leg pain or your neck and arm pain:

☐ 100% **BACK** pain and ☐ 0% **LEG** pain	☐ 100% **NECK** pain and ☐ 0% **ARM** pain
☐ 75% **BACK** pain and ☐ 25% **LEG** pain	☐ 75% **NECK** pain and ☐ 25% **ARM** pain
☐ 50% **BACK** pain and ☐ 50% **LEG** pain	☐ 50% **NECK** pain and ☐ 50% **ARM** pain
☐ 25% **BACK** pain and ☐ 75% **LEG** pain	☐ 25% **NECK** pain and ☐ 75% **ARM** pain
☐ 0% **BACK** pain and ☐ 100% **LEG** pain	☐ 0% **NECK** pain and ☐ 100% **ARM** pain

On a scale of 0 to 10, with 0 being no pain and 10 being your worst pain ever, how would you rate your pain:
Today? 0-1-2-3-4-5-6-7-8-9-10 Weekly average? 0-1-2-3-4-5-6-7-8-9-10

Do you have any muscle weakness? ☐ No ☐ Yes, please explain _____

Do you have any loss of sensation and if yes, where? ☐ No ☐ Yes, please explain _____

_____

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If pain is in your **back and/or legs,** check all that *INCREASE* your pain at this time?

☐ Bending forward ☐ Standing ☐ Twisting right ☐ Bowel movements
☐ Bending backward ☐ Walking ☐ Twisting left ☐ Sneezing / Coughing
☐ Lying on your back ☐ Sitting ☐ Lifting ☐ Other (please describe): _____

If pain is in your **head/neck, shoulders, arms/hands,** check all that *INCREASE* your pain at this time?

☐ Looking up ☐ Turning head to right ☐ Bowel Movements ☐ Sneezing / Coughing
☐ Looking down ☐ Turning head to left ☐ Other (please describe): _____

Check all that *DECREASE* your pain at this time?

☐ Lying on your back ☐ Reclining/Relaxation ☐ Walking ☐ Alcoholic beverages ☐ Heating pad
☐ Lying on your stomach ☐ Sitting ☐ Exercise ☐ Illicit drugs ☐ Cold/Ice packs
☐ Lying on your side ☐ Standing ☐ Moving around ☐ Medications ☐ Nothing
☐ Other (please describe): _____

EFFECTNESS OF TREATMENT:

Have you been to physical therapy for this problem? ☐ No ☐ Yes - Where? _____

For how long? _____ When _____ _____ % overall improvement to date

Have you been to a chiropractor for this problem? ☐ No ☐ Yes - Where? _____

For how long? _____ When _____ What part of body treated? _____

What is your view of chiropractic treatment? ☐ Approve ☐ Disapprove ☐ Indifferent

Have you had any type of surgery for this injury? If so, please indicate any changes in your post-operative pain:

Date	Type of Surgery & Surgeon	Worse	Same	Better
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐

Are you currently doing any daily exercise (including walking) or stretching? ☐ Yes ☐ No

How often? _____ times daily _____ times weekly Length of sessions? _____ minutes per session

Describe your current home exercises, if performed: _____

_____

Please CHECK if you have tried or completed any of the following:

Treatment	Helped	Made Worse	No change	Treatment	Helped	Made Worse	No change
Hot packs	☐	☐	☐	Aerobics (i.e. exercise bike)	☐	☐	☐
Ice	☐	☐	☐	Pelvic (low back)	☐	☐	☐
Massage	☐	☐	☐	Neck Traction	☐	☐	☐
Electrical Stim/TENS	☐	☐	☐	Back / Neck Brace	☐	☐	☐
Strengthening Exercise	☐	☐	☐	Acupuncture	☐	☐	☐
Stretching Exercise	☐	☐	☐	Trigger Point Injections	☐	☐	☐
Epidural Injection	☐	☐	☐	Date(s): _____			
Facet Joint Injection	☐	☐	☐	Date(s): _____			
Sacroiliac Joint Injection	☐	☐	☐	Date(s): _____			
Sympathetic Block	☐	☐	☐	Date(s): _____			

If injections were preformed, were they done with x-ray (fluoroscopic) guidance? ☐ Yes ☐ No

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Have you improved since your injury with treatment to date? If so, please explain: _____

FUNCTIONAL HISTORY: List your hobbies or recreational activities:

Are there any desired activities, including the above, that you cannot do because of your problem? ☐ Yes ☐ No
If so, what are they? _____

Do you have difficulty with normal day to day activities (i.e. getting dressed, driving, or cleaning house)?

SOCIAL HISTORY:

What town do you live in? _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Highest level of education: ☐ Elementary ☐ High School/GED ☐ Trade ☐ College Graduate

OCCUPATIONAL HISTORY:

☐ Currently working regular duties ☐ Unemployed, unable to find work ☐ Student
☐ Currently working modified duties ☐ Unemployed due to spine problems ☐ Retired (not due to health)
☐ On paid leave ☐ Disabled due to health problem not related to spine ☐ Homemaker
☐ On suspension or laid off ☐ Disabled and/or retired because of spine problems ☐ Other: _____

Current Employer? _____ Date of hire for current job? _____
What is your current occupation/job title? _____
How many hours per week do you work? _____ When was the last day you worked "full duty"? _____
Previous employer? _____ If retired, what was your previous occupation? _____
What other jobs/occupations have you had in the last ten years? _____

If you are not working now, what was your occupation/job title when you were injured?

How physically demanding is your job?

☐ Sedentary (essentially no lifting)
☐ Light (frequent lifting of less than 30lbs)
☐ Moderate (frequent lifting of more than 30lbs)
☐ Heavy (frequent lifting of more than 60lbs)
☐ Very Heavy (frequent lifting of more than 100lbs)

Please describe in detail your current job of if unemployed, your most recent job. What are (were) your duties and how much time do you spend standing, sitting, walking, and lifting. _____

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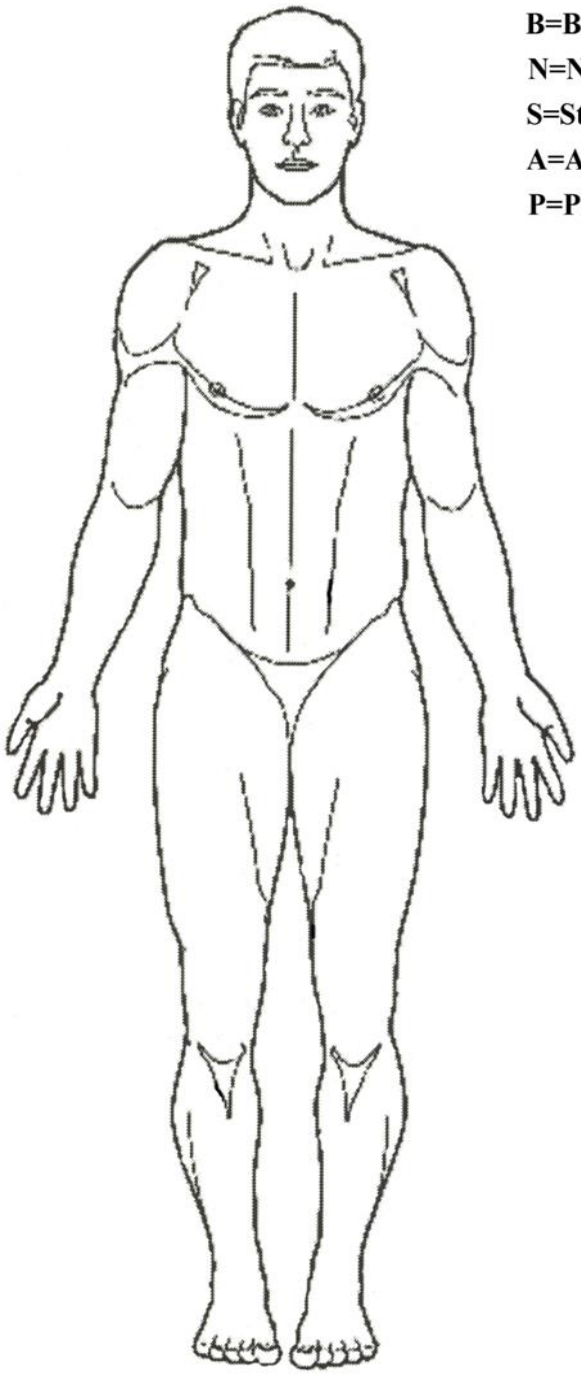
This information is useful for your physician. Mark the drawing below according to how you feel today. Use the figure labeled “Back” for pain on the back of your body and the “Front” for the front of your body. If you have any of the symptoms listed below, indicate where they are located by writing in the following letter on the affected body part:

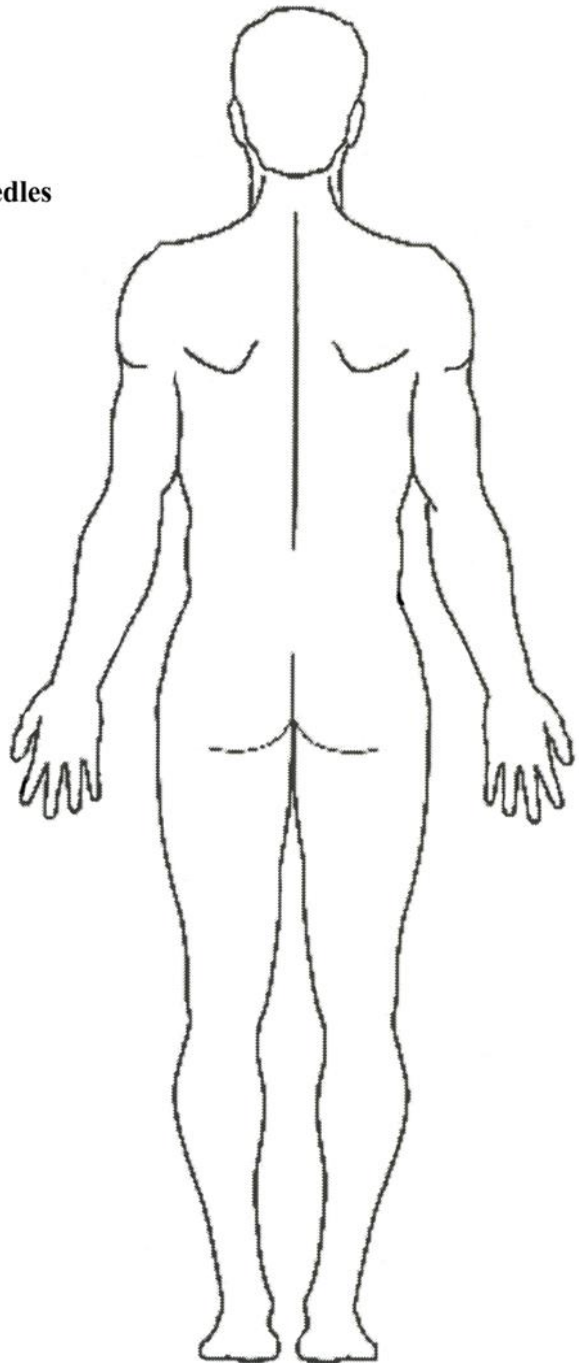
FRONT



Type of Pain

B=Burning
N=Numbness
S=Stabbing
A=Aching
P=Pins & Needles

BACK



Please use this space, if needed, to communicate any additional information that you would like Dr. Kaplan to review for this evaluation _____