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<b>Name:</b>	<b>Age:</b>	<b>Date:</b>
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1. What is your height? \_\_\_\_\_ Weight? \_\_\_\_\_
2. Provide the following for all the medications that are being prescribed to treat your pain:

Medication	Dosage/Frequency	Prescribed By	Medication	Dosage/Frequency	Prescribed By
1.			5.		
2.			6.		
3.			7.		
4.			8.		

3. Please list any allergies you have to medications, including allergies to antibiotics (such as penicillin), x-ray contrast "dye" or latex materials (such as found in rubber gloved and adhesive tape). \_\_\_\_\_
4. Please list any surgeries or hospitalization that you have had (other than those on your spine, bones, or joints). \_\_\_\_\_
5. Is there a family history of severe back or neck pain or other spinal disorders?  Y  N **If yes, please describe:** \_\_\_\_\_
6. Which of the following best describes your current living status?  
 Married                       Divorced                       Single  
 Domestic partnership       Widow or widower
7. Do you have children or other dependents living with you?  Y  N **If yes, provide age and relationship for each.** \_\_\_\_\_
8. Please answer the following questions regarding cigarette and alcohol use.

Do you smoke cigarettes?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have you ever smoked cigarettes?	<input type="checkbox"/> Y <input type="checkbox"/> N
If you have smoked in the past but aren't now, when did you quit? _____	
Do you drink alcohol?	<input type="checkbox"/> Y <input type="checkbox"/> N
If so, how many drinks (beer, wine, liquor) do you have per weeks? _____	

Have you ever had problems with alcohol abuse?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have you ever had problems with abuse of other drugs or chemicals?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have you ever used alcohol or recreational drugs (e.g. marijuana) to relieve your symptoms?	<input type="checkbox"/> Y <input type="checkbox"/> N

9. Have you had any of the following?			
Recent weight gain? How much: _____	<input type="checkbox"/> Y <input type="checkbox"/> N		General weakness? <input type="checkbox"/> Y <input type="checkbox"/> N
Recent weight loss? How much: _____	<input type="checkbox"/> Y <input type="checkbox"/> N		Fatigue? <input type="checkbox"/> Y <input type="checkbox"/> N
Recurrent Fever?	<input type="checkbox"/> Y <input type="checkbox"/> N		Cancer? If yes, describe: _____ <input type="checkbox"/> Y <input type="checkbox"/> N
10. Do you have any problems with your bladder or your bowels? <input type="checkbox"/> Y <input type="checkbox"/> N <b>If yes, complete the following.</b>			
Liver disease?	<input type="checkbox"/> Y <input type="checkbox"/> N		Blood in stools? <input type="checkbox"/> Y <input type="checkbox"/> N
Gallbladder problems?	<input type="checkbox"/> Y <input type="checkbox"/> N		Vomiting blood? <input type="checkbox"/> Y <input type="checkbox"/> N
Loss of appetite?	<input type="checkbox"/> Y <input type="checkbox"/> N		Loss of control of bowels? <input type="checkbox"/> Y <input type="checkbox"/> N
Abdominal pain?	<input type="checkbox"/> Y <input type="checkbox"/> N		Frequent urination? <input type="checkbox"/> Y <input type="checkbox"/> N
Ulcers?	<input type="checkbox"/> Y <input type="checkbox"/> N		Difficulty with urination? <input type="checkbox"/> Y <input type="checkbox"/> N
Reflux or regurgitation?	<input type="checkbox"/> Y <input type="checkbox"/> N		Burning with urination? <input type="checkbox"/> Y <input type="checkbox"/> N
Recurrent nausea or vomiting?	<input type="checkbox"/> Y <input type="checkbox"/> N		Loss of control of urine? <input type="checkbox"/> Y <input type="checkbox"/> N
Recurrent diarrhea?	<input type="checkbox"/> Y <input type="checkbox"/> N		Blood in urine? <input type="checkbox"/> Y <input type="checkbox"/> N
Recurrent constipation?	<input type="checkbox"/> Y <input type="checkbox"/> N		Kidney stones? <input type="checkbox"/> Y <input type="checkbox"/> N
11. Do you have any problems with your eyes? <input type="checkbox"/> Y <input type="checkbox"/> N <b>If yes, complete the following.</b>			
Nearsighted?	<input type="checkbox"/> Y <input type="checkbox"/> N		Conjunctivitis? <input type="checkbox"/> Y <input type="checkbox"/> N
Farsighted?	<input type="checkbox"/> Y <input type="checkbox"/> N		Eye irritation? <input type="checkbox"/> Y <input type="checkbox"/> N
Wear glasses?	<input type="checkbox"/> Y <input type="checkbox"/> N		Double vision? <input type="checkbox"/> Y <input type="checkbox"/> N
Cataracts presently?	<input type="checkbox"/> Y <input type="checkbox"/> N		Blurred vision? <input type="checkbox"/> Y <input type="checkbox"/> N
Cataract surgery?	<input type="checkbox"/> Y <input type="checkbox"/> N		
Glaucoma?	<input type="checkbox"/> Y <input type="checkbox"/> N		
12. Do you have any problems with your skin? <input type="checkbox"/> Y <input type="checkbox"/> N <b>If yes, complete the following.</b>			
Dry skin?	<input type="checkbox"/> Y <input type="checkbox"/> N		Changes in skin color? <input type="checkbox"/> Y <input type="checkbox"/> N
Recurrent rashes?	<input type="checkbox"/> Y <input type="checkbox"/> N		Changes in hair or nails? <input type="checkbox"/> Y <input type="checkbox"/> N
Eczema?	<input type="checkbox"/> Y <input type="checkbox"/> N		Skin cancer? <input type="checkbox"/> Y <input type="checkbox"/> N
Itching?	<input type="checkbox"/> Y <input type="checkbox"/> N		
13. Do you have any food or environmental allergies or immune problems? <input type="checkbox"/> Y <input type="checkbox"/> N <b>If yes, complete the following.</b>			
Food Allergies? If yes, describe: _____	<input type="checkbox"/> Y <input type="checkbox"/> N		Lupus? <input type="checkbox"/> Y <input type="checkbox"/> N
Environmental Allergies? If yes, describe: _____	<input type="checkbox"/> Y <input type="checkbox"/> N		Sjogrens syndrome? <input type="checkbox"/> Y <input type="checkbox"/> N
			HIV/AIDS <input type="checkbox"/> Y <input type="checkbox"/> N
14. Do you have any blood or lymph gland problems? <input type="checkbox"/> Y <input type="checkbox"/> N <b>If yes, complete the following.</b>			
Swollen or enlarged glands?	<input type="checkbox"/> Y <input type="checkbox"/> N		Phlebitis or blood clots? <input type="checkbox"/> Y <input type="checkbox"/> N
Anemia or low blood counts?	<input type="checkbox"/> Y <input type="checkbox"/> N		Blood thinners? <input type="checkbox"/> Y <input type="checkbox"/> N
Easy bruising or bleeding?	<input type="checkbox"/> Y <input type="checkbox"/> N		