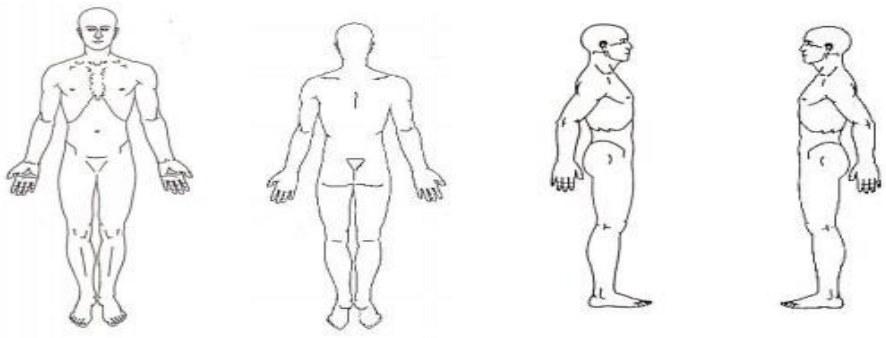
PORTLAND WELLNESS CARE

4160 NE Sandy Blvd. Portland, OR 97212
Ph: (503) 249-9000 Ex#3 Fax: (503) 477-9958

Patient Name:_____ **Date**:_____

1. **Is today's problem caused by**: ☐ Auto Accident ☐ Worker's Compensation ☐ Other

2. **Indicate on the figures below where you have pain/symptoms**:



3. **How often do you experience your symptoms?**

☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

4. **How would you describe the type of pain?**

☐ Sharp ☐ Numb
☐ Dull ☐ Tingly
☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric-like with motion
☐ Stiff ☐ Other:_____

5. **How are your symptoms changing with time?**

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

6. **Using a scale from 0-10 (10 being the worst), how would you rate your symptoms?** (*Please circle*)

0 1 2 3 4 5 6 7 8 9 10

7. **How much have your symptoms interfered with your work?**

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. **How much have your symptoms interfered with your social activities?**

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. **Who else have you seen for this issue?**

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER Physician ☐ Orthopedist ☐ Massage Therapist
☐ Physical Therapy ☐ No one ☐ Other: _____

10. **How long have you had these symptoms?** _____

11. **How do you think your symptoms began?**

_____

12. **Do you consider your symptoms to be severe?**

☐ Yes ☐ Yes, at times ☐ No

13. **What makes your symptoms WORSE?**

_____

14. **What makes your symptoms BETTER?**

_____

15. **What concerns you the most about your symptoms; what do they prevent you from doing?**

_____

16. **What is your**: Height_____ Weight_____ Occupation_____

17. **How would you rate your overall health?**

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

18. **What type of exercise do you do?**

☐ Strenuous ☐ Moderate ☐ Light ☐ None

19. **Do any of your immediate family members have the following:**

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus ☐ Heart Problems
☐ Cancer ☐ ALS ☐ Other: _____

20. **For each of the conditions below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Past	Present	Past	Present	Past	Present
☐	☐ Headaches	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Upper Back Pain	☐	☐ Chest Pains	☐	☐ Frequent Urination
☐	☐ Mid Back Pain	☐	☐ Stroke	☐	☐ Smoking/Tobacco Use
☐	☐ Low Back Pain	☐	☐ Angina	☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain	☐	☐ Kidney Stones	☐	☐ Allergies
☐	☐ Elbow/Upper Arm Pain	☐	☐ Kidney Disorders	☐	☐ Depression
☐	☐ Wrist Pain	☐	☐ Bladder Infection	☐	☐ Systemic Lupus
☐	☐ Hand Pain	☐	☐ Painful Urination	☐	☐ Epilepsy
☐	☐ Hip Pain	☐	☐ Loss of Bladder Control	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Upper Leg Pain	☐	☐ Prostate Problems	☐	☐ HIV/AIDS
☐	☐ Knee Pain	☐	☐ Abnormal Weight Gain/Loss		
☐	☐ Ankle/Foot Pain	☐	☐ Loss of Appetite	**Females Only**	
☐	☐ Jaw Pain	☐	☐ Abdominal Pain	☐	☐ Hormonal Birth Control
☐	☐ Joint Pain/Stiffness	☐	☐ Ulcer	☐	☐ Hormone Replacement
☐	☐ Arthritis	☐	☐ Hepatitis	☐	☐ Pregnancy
☐	☐ Rheumatoid Arthritis	☐	☐ Liver/Gall Bladder Disorder		
☐	☐ Cancer	☐	☐ General Fatigue		
☐	☐ Tumor	☐	☐ Muscular Incoordination		
☐	☐ Asthma	☐	☐ Visual Disturbances		
☐	☐ Chronic Sinusitis	☐	☐ Dizziness		
☐	☐ Other:_____				

21. **List all prescription medications you are currently taking:**

_____

22. **List all over-the-counter medications you are taking:**

_____

23. **List all surgical procedures you have had:**

_____

24. **What activities do you do at work?**

☐ **Sit:**	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ **Stand:**	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ **Computer work:**	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ **On the phone:**	☐ Most of the day	☐ Half of the day	☐ A little of the day

25. **What activities do you do outside of work?**

_____

26. **Have you ever been hospitalized?** ☐ No ☐ Yes

If yes, why?_____

27. **Have you had significant past trauma?** ☐ No ☐ Yes _____

28. **Anything else pertinent to your visit today?**_____

Patient Signature:_____ **Date:**_____