

**Advanced Medicine Alternatives, Ltd.**

*Initial Questionnaire*

Name: \_\_\_\_\_ Age: \_\_\_\_ Sex: M F DOB: \_\_\_\_\_ Today's date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Are you working: (circle one) Full-time Part-time Unemployed Retired

How did you learn about us? \_\_\_\_\_ Who referred you to us? \_\_\_\_\_

**CHIEF REASON FOR TODAY'S VISIT:**

\_\_\_\_\_  
\_\_\_\_\_

When did this problem start? \_\_\_\_\_

If it was an injury, please describe how it happened: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT COMPLAINTS (In order of severity)**

- 1.
- 2.
- 3.

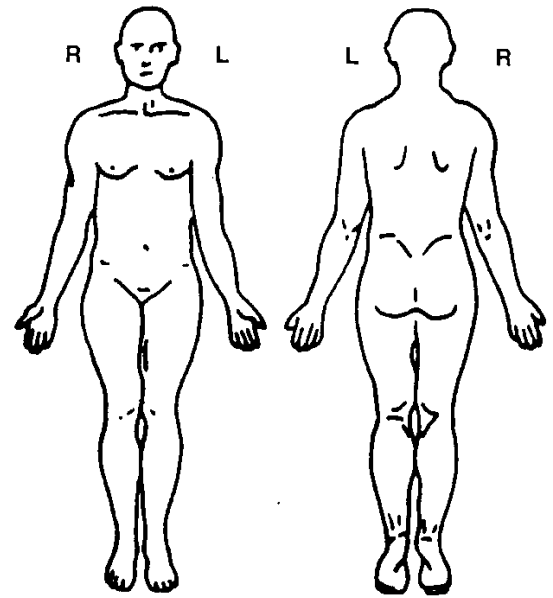
Indicate on the diagram at the right where the pain is located.  
(Mark x's for areas of pain, o's for areas of numbness or tingling.)

Grade the severity of the pain by circling the number that corresponds with the current level:

0 1 2 3 4 5 6 7 8 9 10  
(0 = no pain, 10 = worst possible pain)

Please rate your abilities to do the following activities  
(despite your pain) by circling appropriate response:

- |  |      |      |      |             |
|--|------|------|------|-------------|
| Sleep:   | good | fair | poor | can't do it |
| Light housework:   | good | fair | poor | can't do it |
| Heavy housework:   | good | fair | poor | can't do it |
| Yard Work:   | good | fair | poor | can't do it |
| Sports/recreation:   | good | fair | poor | can't do it |
| Your regular job:  | good | fair | poor | can't do it |
| If you can't do your regular job, please rate your ability to do a Light duty job: | good | fair | poor | can't do it |



The pain is currently: (please check) \_\_\_constant \_\_\_Intermittent \_\_\_Brief

Recently, the pain has been: \_\_\_Getting better \_\_\_Staying the same \_\_\_Getting worse

Recently, your activity tolerance has been: \_\_\_Getting better \_\_\_Staying the same \_\_\_Getting worse

How would you best describe your pain? (check all that apply)

- |              |                        |                       |
|--------------|------------------------|-----------------------|
| ___Sharp     | ___Deep aching         | ___Burning            |
| ___Stabbing  | ___Cramping            | ___Tingling           |
| ___Localized | ___"It hurts all over" | ___"Lightning strike" |

**ASSOCIATED SYMPTOMS:** (please check)

\_\_\_ Numbness      \_\_\_ Weakness of arms or legs      \_\_\_ Loss of bowel or bladder control

When is the pain the worst? (please check)

\_\_\_ Morning    \_\_\_ Afternoon    \_\_\_ Evening    \_\_\_ Night    \_\_\_ No pattern

What is making the pain worse? (check all that apply)

\_\_\_ Bending            \_\_\_ Coughing            \_\_\_ Jarring            \_\_\_ Sitting  
\_\_\_ Lifting            \_\_\_ Sneezing            \_\_\_ Tension            \_\_\_ Standing  
\_\_\_ Reaching            \_\_\_ Bowel movements    \_\_\_ Stress            \_\_\_ Walking  
\_\_\_ Twisting            \_\_\_ Other activities: \_\_\_\_\_

**Which is the worst?** \_\_\_\_\_

What activities cause your pain/symptoms? \_\_\_\_\_

What activities relieve your pain/symptoms? \_\_\_\_\_

What exercises or activities do you enjoy? \_\_\_\_\_

What exercises or activities are you unable to do because of pain? \_\_\_\_\_

What is your primary objective or goal for your treatment? \_\_\_\_\_

How will you define treatment success? Freedom from all pain. Y N      Doing all desired activities. Y N

(please circle)                      Any amount of pain relief Y N      Tolerating simple activities Y N

Other? \_\_\_\_\_

What has been tried to help with the pain? (Please circle correct response)

	<u>Tried?</u>	<u>Helpful?</u>		<u>Tried?</u>	<u>Helpful?</u>
Physical Therapy	Yes/No	Yes/No	Brace or splint	Yes/No	Yes/No
Traction	Yes/No	Yes/No	Home exercises	Yes/No	Yes/No
Ultrasound	Yes/No	Yes/No	Pool exercises	Yes/No	Yes/No
TENS unit	Yes/No	Yes/No	Medications	Yes/No	Yes/No
Massage Therapy	Yes/No	Yes/No	Heat	Yes/No	Yes/No
Acupuncture	Yes/No	Yes/No	Ice (cold packs)	Yes/No	Yes/No
Chiropractic treatment	Yes/No	Yes/No	Restriction of activities	Yes/No	Yes/No
Injections	Yes/No	Yes/No	Other: _____	Yes/No	
Prolotherapy	Yes/No	Yes/No			

**Which is / has been the most helpful?** \_\_\_\_\_

**Which of these are you doing currently?** \_\_\_\_\_

**Name of practitioner for current therapy?** \_\_\_\_\_

**PREVIOUS TREATMENTS / DIAGNOSTIC TESTING**

List any physicians / specialists you have seen for this condition: \_\_\_\_\_

X-rays (results & date) \_\_\_\_\_

MRI (results & date) \_\_\_\_\_

Other test results & dates \_\_\_\_\_

**NOTE: Please bring pertinent x-ray/MRI films *and* written reports with you to your appointment.**

