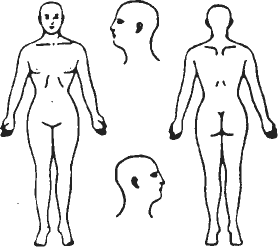
**New Condition Sign In Form**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**We really want to help you with your condition as fast as possible. Please help us understand your condition. Begin by marking where your condition is on the following diagram. Then please answer all of the following questions. Please circle answers when listed. If you have multiple conditions, please fill out additional forms for each separate condition.**



**Where is you condition? Please mark above.**

**What is your condition?** Pain, sickness, soreness, bad feeling, discomfort, uncomfortable feeling, muscle spasm, loss of function, other **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In/of** Head, forehead, back of head, side of head neck mid back , low back , shoulder, arm, forearm, wrist, hand, finger, ribs, chest, stomach, hip, leg, hamstring, thigh, knee (front), knee (back), shin, calf, ankle, foot (top), foot (bottom), heal, big toe, toe,other**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did the condition begin?** Injury, Began due to an activity, I woke up with it, I do not know how it started, other**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When did the condition begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**It Began Gradually or Suddenly?** Gradually, Suddenly

**Is it the result of an Injury or Trauma? Yes, No Please Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is your condition due to an Activity Yes, No**

**What were you doing at the time of the injury or activity?**

**Driving, passenger, riding, lifting, putting down, reaching, throwing, catching, running, walking, sitting, pushing, pulling, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any other reason for onset?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The ailment has been getting: Better, Worse, About the Same**

**What makes your condition better?**

**Activity, Rest, Medication, Heat, Cold, Nutrition, Bracing, Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Activity: Standing, sitting, walking, running, kneeling, stooping, holding things, bending, lifting, pushing, pulling, rising from a seated position, movement, exercise, twisting, certain positions, nothing, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Rest: Lying, Sitting, Sleeping at Night, Upon Waking, During Rest, Sleeping, Rest during day, Rest during evening, inactivity, lying down, certain positions, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication over the counter: Aspirin (Anacin/Bayer/Bufferin/Ecotrin), Acetaminophen (Anacin non-Aspirin/Excedrin/Tylenol), Combination of Aspirin (NSAID) and Acetaminophen (Vanquish), Ibuprophen (Advil, Motrin, Nuprin, Motrin 800)**

**Naproxen Sodium (Aleve/Naproxen), Ketoprofen(Acton/Orudis) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication (prescription)**

**Celocoxib (Celebrex), Tramadol (Ultram), Meperidine HCL (Demerol), Oxycodone HCL (Oxycontin 40), Hydrocodone and Acetaminophen (Lorcet/Vicodin.Lorcet Plus, Vicodin ES/Lortab/Vicodin HP), Hydrocodone-APAP and Acetaminophen (Norco), Oxycodon HCL with Acetaminophen (Percocet), Oxycodone HCL, Oxycodone Terephthalate and Aspirin (Percodan), Morphine Sulphate (RMS/MS Contin), Fentanyl (Duragesic/Fentora, Actiq), Hydromorphone Hydrocloride (Also Known As Dihydromorphinone (Dilaudid (tabs)/Palladone (caps), Oxymorphone (Opana ER), Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What makes your condition worse?**

**Activity, Rest, Medication, Heat, Cold, Nutrition, Bracing, Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Activity: Standing, sitting, walking, running, kneeling, stooping, holding things, bending, lifting, pushing, pulling, rising from a seated position, movement, exercise, twisting, certain positions, nothing, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Rest: Lying, Sitting, Sleeping at Night, Upon Waking, During Rest, Sleeping, Rest during day, Rest during evening, inactivity, lying down, certain positions, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Can you describe your pain? Yes, No**

**If Condition is painful, describe your pain:**

**Is the pain deep or superficial? Deep, Superficial**

**Is the pain sharp or dull? Sharp, Dull**

**Is the pain constant or intermittent: Constant, Intermittent**

**If intermittent, how many episodes per day? Nearly constant, frequent, infrequent, occasional**

**Describe the pain:**

**Burning, tingling, aching, throbbing, gnawing, stiffness, tired, numbness, stabbing, shooting, radiating, constant dull ache becoming sharp with movements or activities, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your pain radiate? Yes, No**

**If yes: Where does it start? Where does it go? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**How severe is your pain right now 0 (none), 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (Worst)**

**Where does it range from? 0 (none), 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (Worst) to 0 (none), 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (Worst)**

**Is the pain worse at any time during the day or day of the week or month? No, Sometimes, morning, Afternoon, Night, When Sleeping, Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had anything like this before? Yes, No**

**When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Has there been any change in your bodily functions? No, Urination, Defection, Respiration, Digestion, Vision, Sexual, Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you done anything at home attempting to help? Over the counter medication, rubbing compound, massage, ice, heat, hot soaking, hot shower, exercise, rest, lying down, stretching, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What other professional treatment have you received for this treatment? Medical Doctor, Chiropractor, Massage Therapist, Naturopathic Doctor, Acupuncturist, Dentist, Podiatrist, Medications, Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has the condition affected your daily activities? Yes, No**

**How? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**If multiple conditions the following questions are only answered once.**

**If employed, how have conditions affected workload? None, Off Work, Temporarily Totally Disabled, Light Duty, Regular Duty, Limited Duty**

**Have You Seen Another Doctor Since your last visit? Yes, No**

**Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tobacco Use: Current everyday smoker, Current some day smoker, former smoker, never smoker, smoker**

**Is sleep disturbed by these conditions? Yes, No**

**What positions do you sleep in? Back, side, stomach, multiple, other**

**What do you sleep on? Mattress, Waterbed, Futon, Air Bed, Foam Mattress, Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Alcohol Use: None, Occasional, Frequent, Daily, Socially, Infrequent, Weekends**

**Please describe your occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What are your hobbies?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What Medications are you taking (Please indicate name of medication, dosage and form (example 2 x 300 mg tablets), Frequency (Example 3 x per day)) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies: No known allergies**

**Allergies to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**How Does it affect you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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