ADVANCED BODY SOLUTIONS, Inc

Patient: _____ DOB: _____

Current Injury / Area of Complaint

Area(s) of Complaint: ◯ Head or Cervical Spine ◯ Upper back or Thoracic Spine ◯ Lower back or Lumbar Spine ◯ Sacrum or Pelvis ◯ Right Hip or Leg ◯ Left Hip or Leg ◯ Right Shoulder or Arm ◯ Left Shoulder or Arm ◯ Other:_____

Does the pain radiate to other body parts? ◯ Yes ◯ No Where:_____

Have you had surgery on the area of complaint? ◯ Yes ◯ No Surgery Type & Date:_____

Are the result of: An Accident or injury from ◯ Work ◯ Auto ◯ Other_____

Are you Currently Pregnant? ◯ Yes ◯ No Due Date:_____

Onset: Initial onset of symptoms or date of injury:_____

Intensity: (Rate your symptoms) No Pain (Zero) **0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10** Chop it off (Ten)

Duration and Frequency:

How often does it affect your daily living?

◯ Constant (76-100%)
◯ Frequent (51-75%)
◯ Intermittent (26-50%)
◯ Occasional (0-25%)
◯ Other_____
_____
_____
_____

Symptom Quality:

◯ Numbness
◯ Tingling
◯ Shooting
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Sharp
◯ Burning
◯ Other _____

Prior Therapies / Treatments tried:

◯ Ice
◯ Heat
◯ Surgery
◯ Chiropractic
◯ Physical Therapy
◯ Acupuncture
◯ Massage
◯ Prescription Medication
◯ Over the counter Drugs
◯ Other _____

Aggravating or Relieving factors:

Makes Problem Worse:_____

Makes Problem Better:_____

Does your current condition interfere with Daily Function? (Circle one for each)

Sitting	None	Mild	Moderate	Severe	Caring for family	None	Mild	Moderate	Severe
Standing	None	Mild	Moderate	Severe	Household Chores	None	Mild	Moderate	Severe
Rising out of a chair	None	Mild	Moderate	Severe	Lifting objects	None	Mild	Moderate	Severe
Walking	None	Mild	Moderate	Severe	Shoveling	None	Mild	Moderate	Severe
Running	None	Mild	Moderate	Severe	Yard Work	None	Mild	Moderate	Severe
Laying down	None	Mild	Moderate	Severe	Reaching overhead	None	Mild	Moderate	Severe
Bending over	None	Mild	Moderate	Severe	Showering / bathing	None	Mild	Moderate	Severe
Climbing stairs	None	Mild	Moderate	Severe	Dressing	None	Mild	Moderate	Severe
Using a computer	None	Mild	Moderate	Severe	Getting / Staying asleep	None	Mild	Moderate	Severe
Getting in/out of car	None	Mild	Moderate	Severe	Concentrating	None	Mild	Moderate	Severe
Driving a car	None	Mild	Moderate	Severe	Looking over shoulder	None	Mild	Moderate	Severe

Additional Information:_____

_____

Patient Signature:_____ **Date:**_____

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Past Medical History

Please indicate if you have had any of the following:

☐Alcoholism	☐Embolism	☐Measles	☐Rheumatic Fever
☐Allergy Shots	☐Emphysema	☐Migraine Headaches	☐Scarlet Fever
☐Anemia	☐Epilepsy	☐Mononucleosis	☐Stroke
☐Appendicitis	☐Glaucoma	☐Multiple Sclerosis	☐Thyroid Problems
☐Arthritis	☐Goiter	☐Mumps	☐Tonsillitis
☐Asthma	☐Gout	☐Osteoporosis	☐Tuberculosis
☐Bleeding Disorders	☐Heart Disease	☐Pacemaker	☐Tumors / Growths
☐Breast Lump	☐Hepatitis	☐Parkinson's Disease	☐Typhoid Fever
☐Bronchitis	☐Hernia	☐Pinched Nerve	☐Ulcers
☐Cancer	☐Herniated Disk	☐Pneumonia	☐Vaginal Infections
☐Cataracts	☐High Blood Pressure	☐Prostate Problems	☐Whooping Cough
☐Chicken Pox	☐High Cholesterol	☐Prosthesis	Other:_____
☐Diabetes	☐Kidney Disease	☐Psychiatric Care	_____
☐ Eating Disorders	☐Liver Disease	☐Rheumatoid Arthritis	_____

Daily Living: Please indicate any that apply:

Daily Exercise	**Work Type**	**Habits**
☐ None	☐ Sitting	☐ Smoking Packs/Day_____
☐ Light	☐ Standing	☐ Alcohol Drinks/Week_____
☐ Moderate	☐ Light Labor	☐ Caffeinated Drinks Cups/Day_____
☐ Heavy	☐ Heavy Labor	☐High Stress Levels Reason_____

Female Reproductive History:

Number of pregnancies: _____ Number of children: _____ Deliveries by C-Section or Vaginally

Injuries: Have you ever…

◯ had a fracture or broken a bone ◯ used a crutch or other support ◯ been injured in an accident
◯ had a spine or nerve disorder ◯ used a neck or back brace ◯ been knocked unconscious
◯ other: _____

Surgeries (include date):

◯ Appendix removal __/__ ◯ Eye Surgery __/__ ◯ Spine: __/__ _____
◯ Bypass surgery__/__ ◯ Hysterectomy__/__ ◯ Elective surgery: __/__ _____
◯ Cosmetic surgery__/__ ◯ Pacemaker__/__ ◯ Tonsillectomy __/__
◯ Other (Please include date):

_____

_____

Allergies:_____

_____

Medications:_____

_____

Patient Signature:_____ **Date:**_____