

NEUROCARE CENTER, INC.

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Name _____ DOB: ____/____/19 _____ Age: _____

**Please complete this form thoroughly and legibly in ink.
This will help your doctor provide the best care possible.**

NATURE OF PRESENTATION:

(Check one)

HANDEDNESS RIGHT
 LEFT
 AMBIDEXTROUS

Main reason for this visit: _____

MECHANISM OF INJURY: Work Related? Yes _____ No _____

Date problem began: _____

Describe all details of any accident, incident, or the way this pain began: _____

Answer the following if you were involved in a motor vehicle accident:

(Check one)	YES	NO		YES	NO
SEAT BELT	_____	_____	HEAD ON	_____	_____
DRIVER	_____	_____	ROLLOVER	_____	_____
BROADSIDE	_____	_____	TAILSPIN	_____	_____
REAR END	_____	_____	EXPLAIN	_____	_____

LEVEL OF PAIN: (Rating Scale: 0 = No Pain 10 = Worst Pain Imaginable)
 Please indicate the level (on a 1-10 scale) of pain you have experienced.

TODAY _____ BEST DAY _____ WORST DAY _____

How would you describe your pain? (Check all that apply.)

DULL _____	BURNING _____	ACHING _____
SHARP _____	THROBBING _____	CONSTANT _____
SUPERFICIAL _____	SHOOTING _____	INTERMITTEN _____
DEEP _____	STABBING _____	OTHER _____

How would you describe your current pain ratio? (Check one.)

100% back pain, 0% leg pain _____	100% neck pain, 0% arm pain _____
75% back pain, 25% leg pain _____	75% neck pain, 25% arm pain _____
50% back pain, 50% leg pain _____	50% neck pain, 50% arm pain _____
25% back pain, 75% leg pain _____	25% neck pain, 75% arm pain _____
0% back pain, 100% leg pain _____	0% neck pain, 100% arm pain _____

Do you have headaches? Yes _____ No _____

If yes, how often and how long do they last; and where are they located? _____

SLEEP:

YES

NO

Does the pain wake you up at night? _____

Are you sleeping soundly? _____

How many hours do you sleep each night? _____

Have you ever taken medication to help you sleep at night? _____

If YES, what medication? _____

AMELIORATING/EXACERBATING FACTORS:

Check which of the following activities change the nature of your pain:

	Aggravates Pain	No Change	Relieves Pain
When I first get out of bed	_____	_____	_____
Getting up	_____	_____	_____
Sitting	_____	_____	_____
Standing	_____	_____	_____
Leaning Forward	_____	_____	_____
Walking	_____	_____	_____
Lying on my side	_____	_____	_____
Lying on my back	_____	_____	_____
Lying on my stomach	_____	_____	_____
Driving	_____	_____	_____
Coughing/sneezing	_____	_____	_____
Stooping	_____	_____	_____
Lifting	_____	_____	_____
Bending backward	_____	_____	_____
Twisting	_____	_____	_____
Other	_____	_____	_____

Have you had back/neck problems before? YES _____ NO _____ If yes, describe below:

Injury

Date

Treatment

Months off Work

PREVIOUS EVALUATION AND TREATMENT

Have you seen any other doctors, clinics, E.R., or therapists for your current problem? Please list:

Name

Address

Date of first visit

Date of last visit

Have you had any of the following? (Check all that apply.)

	YES	NO	LAST DATE	WHERE DONE
Myelogram	_____	_____	_____	_____
MRI	_____	_____	_____	_____
CT Scan	_____	_____	_____	_____
Bone Scan	_____	_____	_____	_____
Regular Spine X-ray	_____	_____	_____	_____
Discogram(s)	_____	_____	_____	_____
Facet Block(s)	_____	_____	_____	_____
Epidural(s)	_____	_____	_____	_____
EMG Test	_____	_____	_____	_____

Please indicate which of the following have been used to treat your present condition. Also, indicate whether the treatment was helpful or not. (Check all that apply.)

	YES	NO	HELPFUL	NOT HELPFUL	WORSE	NO. OF
Physical Therapy Hot/Ice packs, massage, muscle stimulation, ultrasound, etc.	_____	_____	_____	_____	_____	_____
Exercises for proper posture (Stabilization)	_____	_____	_____	_____	_____	_____
Exercises to build strength/endurance (bike, treadmill, etc.)	_____	_____	_____	_____	_____	_____
Back school education	_____	_____	_____	_____	_____	_____
Work Hardening/Conditioning	_____	_____	_____	_____	_____	_____
Traction	_____	_____	_____	_____	_____	_____
Chiropractic Adjustment	_____	_____	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____	_____	_____
Epidural Injection	_____	_____	_____	_____	_____	_____
TENS Unit	_____	_____	_____	_____	_____	_____
Medicines	_____	_____	_____	_____	_____	_____
Pain/Stress Management	_____	_____	_____	_____	_____	_____
Relaxation Techniques	_____	_____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____	_____	_____

Do you have allergies to any of the following?

	YES	NO	If yes, please list ALLERGIES
Allergic to medicines	_____	_____	1 _____
Allergic to dyes	_____	_____	2 _____
Allergic to Iodine	_____	_____	3 _____
Malignant hyperthermia?	_____	_____	4 _____
Bleeding tendency in family or yourself	_____	_____	5 _____
Have you had difficulty with anesthesia?	_____	_____	6 _____

If yes, describe: _____

PAST MEDICAL HISTORY

Please list all past HOSPITALIZATIONS, all previous SURGERIES, and MEDICAL CONDITIONS:

If none, please write NONE.

Illness/Surgery	Hospital	Date
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FAMILY HISTORY

	Alive and Well	Died	Age	Cause of Death	Had/has a problem similar to yours?
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____

SOCIAL HISTORY

Are you: (Check one) Single Married Separated
 Divorced Widow Widower

If married, age, health, and vocation of spouse:

Age _____ Health _____ Vocation _____

How much schooling have you completed? (Check one)

- Less than high school _____
- Graduated from high school _____
- Completed 1-3 years of college _____
- Graduated with an Associate Degree or Technical School _____
- Graduated from college (Bachelors degree or equivalent) _____
- Completed post-graduate or professional degree _____

SOCIAL HISTORY

Who resides in your home? _____

If children:	YES	NO	If children:	YES	NO
Age _____	Living at home _____	_____	Age _____	Living at home _____	_____
Age _____	Living at home _____	_____	Age _____	Living at home _____	_____
Age _____	Living at home _____	_____	Age _____	Living at home _____	_____

Do you use any of the following? (Check all that apply.)

	YES	NO	TYPE	AMOUNT PER DAY
Drug(s)	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____

Have you ever had problems with alcohol or drug abuse? YES _____ NO _____

Please list your hobbies: _____

OCCUPATIONAL HISTORY

Name of employer: _____

Occupation: _____ How Long? _____

Date you last worked _____ Previous employment: _____

Describe your duties: _____

How many hours of your usual day do you spend:

	<u>Hours</u>		<u>Hours</u>
Sitting	_____	Driving	_____
Standing	_____	Lifting	_____
Walking	_____	How heavy?	_____

How much do you like your occupation?

List any other associated problems not covered in this questionnaire: _____

Signature

Date