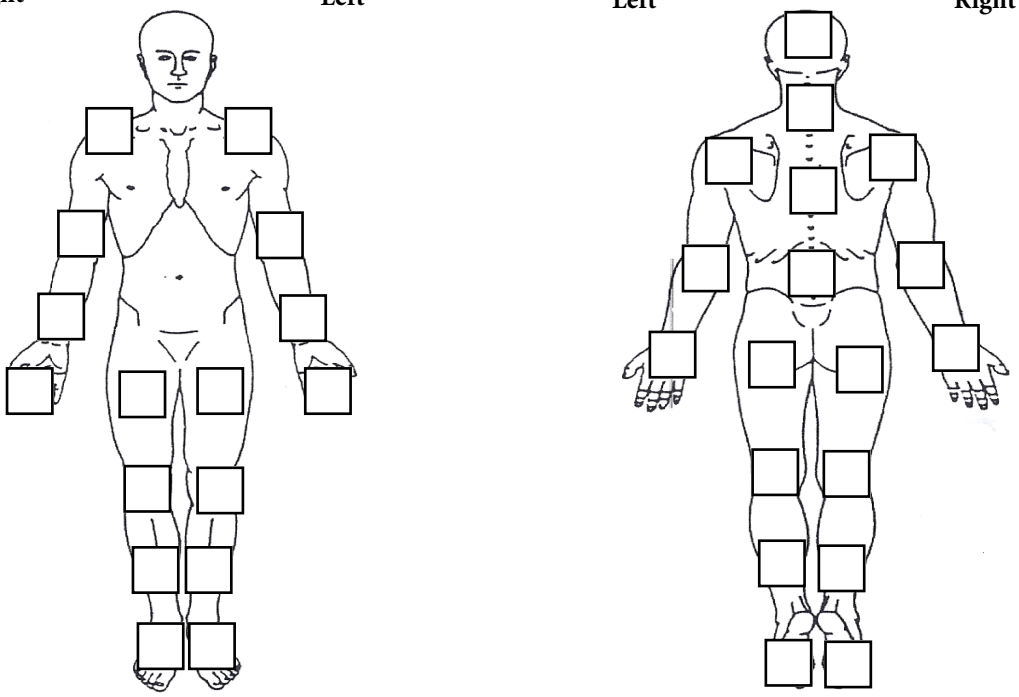
ADVOCATE HEALTH
PARTNERS

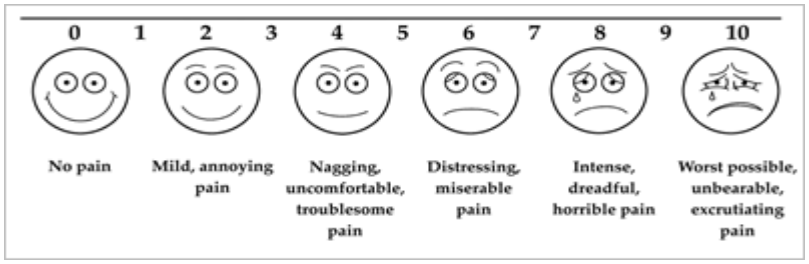
NAME: _____ TODAY'S DATE: _____
Date of Birth: _____ SSN: _____
Address:_____
Best contact phone# _____ Email: _____

BODY PAIN DIAGRAM INSTRUCTIONS
Indicate where you are having symptoms by using the proper symbols and arrows to show where the pain goes or shoots. Be sure to show all areas involved and please indicate where the pain is the worst

Aching/pain	**(xxxx)**	**Burning**	**(//////)**
Numbness/Tingling	**(oooo)**	**Spasm/cramp**	**(#####)**
Pins/needles	**(-------)**		

Right **Left** **Left** **Right**





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Patient Name:_____

HISTORY OF PRESENT ILLNESS:

What is your chief complaint: _____

When did your symptoms begin? _____

1. Were you involved in any type of the listed traumatic injuries? ☐ YES ☐ NO (If yes continue, if no skip to #2)

☐ Auto Accident ☐ Slip and fall ☐ Other: _____ DATE OF ACCIDENT: _____

After the traumatic injury, when did you notice your symptoms occur? ☐ Immediately ☐ Hours later ☐ Days later

Have you experienced similar symptoms in the past twelve months? ☐ YES ☐ NO

If YES, please explain:_____

Following the traumatic injury, did you; ☐ Go home ☐ Go to work ☐ Go to the hospital

Other: _____

2. Have you been hospitalized due to your current symptoms: ☐ YES ☐ NO
(If you did not go to the hospital skip this portion)

Date of your first hospital visit: _____ *Hospital Name:* _____

Please indicate what testing you have completed? Circle all that apply: ☐ *X-Ray* ☐ *MRI* ☐ *CT Scan*

☐ *CT Myelogram* ☐ *EMG / Nerve Conduction Test* ☐ *Other:* _____

3. What treatment have you had since your symptoms began? Circle all that apply:

☐ Chiropractic care ☐ Physical Therapy ☐ Surgery ☐ Injections/RFA

☐ Medications ☐ Massage ☐ Other:_____

4. What make your symptoms worse? Circle all that apply: ☐ Standing ☐ Walking ☐ Sitting

☐ Bending ☐ Lifting ☐ Going from sit to stand ☐ Other: _____

5. What makes your symptoms better?

_____

6. What types of activities or hobbies do you like to participate in but have not been able to or have been limited in doing because of your current level of pain?

_____

_____

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Patient Name: _____

PREFERRED PHARMACY and Phone Number:

_____

PRIMARY CARE PHYSICAIN NAME and PHONE NUMBER:

_____

Current Prescription medications/ Current Vitamins, Supplements, Herbal and Over the Counter medications:

_____

_____

_____

List any ALLERGIES to medication, latex, iodine, contrast dye or shellfish? List medications below:

_____

_____

PAST MEDICAL HISTORY: Do you have history of the following conditions?

- ☐ NONE
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ OTHER: _____
- ☐ Cancer (Type:_____)
- ☐ Coronary Artery Disease
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Osteoarthritis
- ☐ Thyroid Disease
- ☐ Kidney Disorder
- ☐ Osteoporosis
- ☐ Stroke

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Patient Name:_____

Please list all previous surgeries:

_____

_____

FAMILY HISTORY

Please circle any chronic illnesses that have affected close family members.

Mother: Alive? ☐ Yes ☐ No

☐ No Health Concerns ☐ Heart Disease ☐ Arthritis ☐ Diabetes ☐ Asthma

☐ Bleeding Disorder ☐ High Cholesterol ☐ Hypertension ☐ Mental Illness

Father: Alive? ☐ Yes ☐ No

☐ No Health Concerns ☐ Heart Disease ☐ Arthritis ☐ Diabetes ☐ Asthma

☐ Bleeding Disorder ☐ High Cholesterol ☐ Hypertension ☐ Mental Illness

ADVOCATE HEALTH
PARTNERS

Patient Name:_____

SOCIAL HISTORY

Do you smoke cigarettes? ☐ **Yes** ☐ **No**

If yes, how many packs per day?_____ **How many years?**_____

Have you quit smoking? ☐ **Yes** ☐ **No**

If yes, how long ago?_____

Do you drink alcohol on a regular basis? ☐ **Yes** ☐ **No**

If yes, how many drinks per day?_____

Do you exercise on a regular basis? ☐ **Yes** ☐ **No**

If yes, how often? _____

Do you currently work? ☐ **YES** ☐ **NO**

If yes, what type of work? _____

If you are not working, are you; ☐ **Retired** ☐ **Disabled**

Patient Printed Name: _____

Patient/Guardian Signature: _____

Date: _____