Active SPINE

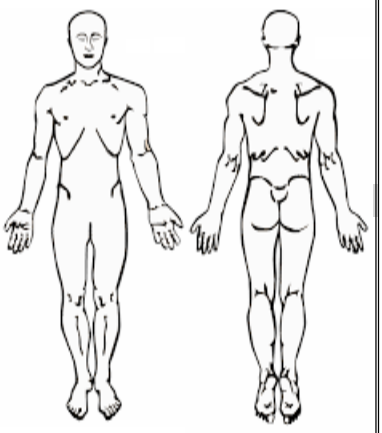
6209 S Old Village Place, Sioux Falls, SD 57108 (605) 271-8277 Beactiveinc.com

First Name: _____ Last Name: _____

Height: _____ Weight: _____ lbs

HISTORY OF PRESENT COMPLAINT: (circle that apply)

-Chief Complaint: _____



-Type of Complaint: Dull Ache Stiff Sharp Burning
Sharp at Times Sharp w Movement Other: _____

-Cause of Complaints: _____

Duration and Frequency of Complaint (circle that apply)

-Duration of Complaint: _____(many) days weeks months years

- OR -Specific Date of Injury: _____

-Frequency of Complaint 0-24% 25-49% 50-74% 75-100% of the day

-Timing of Complaint: Morning Evening Progresses throughout the day

-Radicular complaints: Non Radiating OR Radiates to: _____

-Change in complaint since pain started: Better Worst No Change

Severity of Complaint (circle that apply)

-Severity of complaint: Mild Mild to Moderate Moderate Moderate to Severe Severe

-Pain Scale: 0 1 2 3 4 5 6 7 8 9 10 (0 no pain- 10 unbearable)

Improving and Aggrevating Factors (circle that apply)

-Symptoms improved by: Rest Stretches Movement Ice Heat OTC Rx Injections

-Symptoms aggravated by: Walking Standing Sit to stand Lifting Running Swimming Reaching Sleeping
Overhead Act Other: _____

Associated Signs/Symptoms of Current Complaint (circle that apply)

Denies All Fever/Flu Ongoing Dizziness Difficulty Breathing Chest Pain Vision Changes Auditory Changes
Bowel Changes Bladder Changes Excessive Fatigue Urinary Pain Saddle Numbness Unexplained Wt Loss

Previous Episodes and Care

-Other Physicians Seen for Current Complaint? Yes or No Result of Treatment

MD: _____ Treatment Provided: _____

DC: _____ Treatment Provided: _____

PT: _____ Treatment Provided: _____

-Recent Diagnostic Testing: Yes No Date: _____

If yes, what type of Test: Xray MRI CT Bone Scan Other:

Results of Testing: _____

-Previous Episodes of Current Complaint: Yes No

If so, when: _____

Please Discribe: _____

-Any changes in recent health history, surgical history, family medical history or medications: Yes No

If yes, please explain: _____

Other Pertinant Information
related to your condition: _____

SIGNATURE: _____ DATE: _____