Date: _____

Name: _____
Last First M.I.

DOB: _____ Age: _____

Benjamin P. Crane M.D.

Please complete this form. Your careful answers will help us to understand your presenting problem and design the best treatment program for you.

Chief complaint/Main Problem: _____

When did your current problem start? _____/_____/_____ (month/day/year)

Have you ever had similar problems before? ☐ yes ☐ no If yes, please explain:

_____

_____

USING SYMBOLS BELOW, MARK DRAWING ACCORDING TO YOUR PAIN. INCLUDE ALL AFFECTED AREAS

Ache/sore: >>>
Cramping: ccc
dull: DDD
pressure: ppp
burning: BBB
sharp: sss
tingling: xxx
shooting: +++
numb: nnn
stabbing: ///
throbbing: TTT
pins/needles: ooo

Neck Pain: Circle Severity Level

0 1 2 3 4 5 6 7 8 9 10

Minor Moderate Severe

☐ Neck pain worse that shoulder/ arm pain

☐ Neck pain same as shoulder/ arm pain

☐ Neck pain less than shoulder/ arm pain

Upper back: Circle Severity

Pain Level

0 1 2 3 4 5 6 7 8 9 10

Minor Moderate Sever

Low Back Pain: Circle Severity

Pain Level

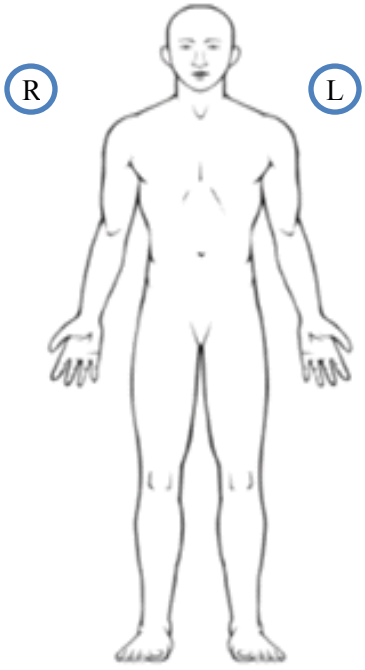
0 1 2 3 4 5 6 7 8 9 10

Minor Moderate Sever

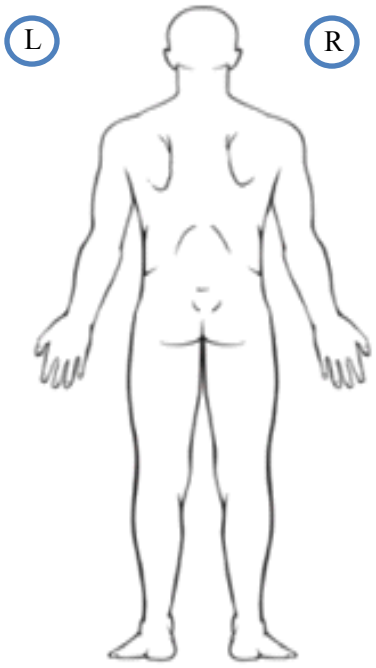
Back pain worse than hip/leg pain

Back pain same as hip/leg pain

Back pain less than hip/leg pain



FRONT



BACK

CIRCLE ANY THAT APPLY

ARE YOU GETTING:
Better
Worse
Unchanged

ARE YOU USUALLY IN:
Mild discomfort
Moderate discomfort
Sever discomfort

PAIN IS WORSE IN THE:
Morning (6am-Noon)
Afternoon (1pm- 3pm)
Night (6pm-6am)

DOES PAIN COME ON:
Suddenly
Gradually

PAIN IS:
Constant
Good & bad days

Are you working? ☐ Yes ☐ No If not, when did you stop? _____
Is the problem the result of an on-the-job injury? ☐ Yes ☐ No
Do you have an attorney helping you? ☐ Yes ☐ No

Is this problem the result of a motor vehicle crash (MVC)? ☐ Yes ☐ No If yes, please check, circle or highlight one of the following:

MVC/Driver (E812.0)
Motorcyclist (E810.2)
MVC vs. Bike (E813.6)
MVC/Passenger (E812.1)
Motorcycle/Passenger (E810.3)
MVC vs. Pedestrian (E614.7)
Pedestrian Hit by Car (E812.7)

Is this problem the result of a fall? ☐ Yes ☐ No If yes, please check, circle or highlight one of the following:

At Home (E888.8)
Sidewalk/Curb (E880.01)
Snow Skis (E885.3
Water Skis (E835.4)
Stairs (E880.9)
Tree (E884.9)
Snowboarding (E885.4)
Chair (E884.2)
Ladder (E881.0)
Inline Skate (E885.1)
Commode (E884.5)
Scaffolding (E881.1)
Skateboard (E885.2)

Which INCREASES your pain/discomfort? Please check or circle:

Standing
Sitting
Walking
Bending forward
Bending backward
Lying on back
Lying on stomach
Lying on side
Getting out of bed
Raising from sitting
Coughing/Sneezing
Urination
Bowel movement
Driving
Heat
Cold

Which DECREASES your pain/discomfort? Please check or circle:

Standing
Sitting
Walking
Bending forward
Bending backward
Lying on back
Lying on stomach
Lying on side
Getting out of bed
Raising from sitting
Coughing/Sneezing
Urination
Bowel movement
Driving
Heat
Cold

What is the approximate amount of time you can perform the following activities?

Sit _____ minutes Stand _____ minutes Walk _____ minutes

For your current problem, have you had (Please List Dates if Available):

X-ray MRI CT Scan Myelogram EMG Bone Scan Discogram

Please check or circle all of the treatments you have tried for your pain and then check the appropriate:

√	Treatment	Date (approx.)	No Relief	Moderate Relief	Excellent Relief
	Physical/Occupational Therapy				
	Heat/Ice				
	Traction				
	Injections (epidural, facet, etc.)				
	TEN – Electrical Stimulator				
	Ultrasound				
	Brace or collar				
	Massage				
	Psychotherapy - Biofeedback				
	Chiropractic				
	Dorsal Column Stimulator				
	Morphine pump				
	Other				

Height: _____ Weight: _____

MEDICATIONS: (List all medications you are currently taking)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Pharmacy: _____ **Location**: _____ **Phone#**: _____

Allergies: List all allergies

_____ _____

_____ _____

_____ _____

1. Constitutional	Night-Sweats Fever/Chills Weight Loss/Gain _____lbs.(in the last year) None
2. Eyes	Visual Changes Glasses/Contacts None
3. Ear, Nose, Throat	Hearing Problem Sore Throat Cold Sinus Allergies None
4. Cardiovascular	Chest Pain Palpitations Leg Swelling Calf Cramps with Walking None
5. Sexual Function	Impotence Painful Intercourse Not Sexually Active None
6. Respiratory	Short of Breath Wheezing Frequent Cough Coughing up Blood None
7. Gastrointestinal	Ulcer Bowel/Bladder Control Problem Diarrhea Vomiting None
8. Genitourinary	Incontinence Burning While Urinating Blood in Urine Kidney Stones None
9. Musculoskeletal	Backache Joint Stiffness Joint Swelling Join Pain None
10. Integumentary	Rash Hair Problem Nail Problem None
11. Neurological	Headaches Fainting Memory Loss Tingling/Numbness none
12. Psychiatric	Depression Anxiety Personality Change Previous Psych Care None
13. Endocrine	Excessive Urination Excessive Thirst Intolerance to Heat/Cold None
14. Hematologic/Lymphatic	Abnormal Bleeding Anemia None
15. Allergic/Immunologic	Immunization Problems Allergy Shots None

PAST MEDICAL HISTORY: Circle any illnesses you currently have, or have had in the past.

Hypertension
A-fibrillation
Seizures
Depression
Asthma
Irritable Bowl
Thyroid Disease
Rheumatoid Arthritis

Renal Failure/Dialysis
Diabetes
Heart Attach/arrhythmia
CHF
Blood Clots
HIV
Osteoarthritis
High Cholesterol

Emphysema
GERD/Reflux
Elevate live tests
Osteoporosis
Drug/Alcohol
Dependency
Stroke
Gastric Ulcer
Hepatitis

OTHER:

_____

_____

_____

Have you had any falls in the last year? Yes No

Did the fall result in any injury? Yes No

If YES, Please provide details: _____

Have you ever had a Pneumonia Vaccination? Yes No If YES, Approx. date: _____

PAST SURGICAL HISTORY

Tonsils/Adenoids	Hysterectomy	D-fib	Neck Surgery
Appendectomy	Bladder Suspension	Coronary Bypass	Back Surgery
Gallbladder	Vasectomy	Biopsies of: _____	
Hernia	Prostate	Fracture repair: _____	
Cataracts	Pacemaker	Joint Replacement: _____	

OTHER:

_____

_____

FAMILY HEALTH HISTORY:

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

SOCIAL HISTORY:

MARITAL STATUS: Single Married Widowed Divorced

Do you smoke cigarettes? Yes No Former smoker? Pack/Day _____ # of Years _____

Do you dip/chew tobacco? Yes No

Do you drink alcohol? Yes No Drinks/Week _____

Occupation: _____ Highest Education Level: _____

Is your job: _____ sedentary _____ light _____ medium _____ heavy?

Are you _____ right _____ left handed?

Race: Ethnicity: Preferred Language: _____