William James Brooks, DO, PC

Board Certified - Osteopathic Manipulative Medicine

Restorative Care of Musculoskeletal Pain Syndromes and Headache

Please review the entire form prior to answering. Thank you!

NAME _____ DATE OF BIRTH _____

ADDRESS _____

City _____ State _____ Zip _____

PHONE (H/W) _____ (Mobile) _____

REFERRED BY _____

MARITAL STATUS: M S W D VET STATUS: N Y Combat?

EDUCATION (Degree or last grade completed) _____

SPOUSE & CHILDREN ***or*** PARENTS & SIBLINGS: Name, Age, Gender, Health Status

_____

_____

_____

_____

OCCUPATIONAL HISTORY _____

DISABLED: N Y Since? _____ Why? _____

Income Source(s) _____ Sufficient for needs? N Y

Handed: Right Left Both If both, describe. _____

HEALTH MAINTENANCE

CURRENT EXERCISE PROGRAM _____

_____

_____

PRIMARY CARE PHYSICIAN _____

Year of last physical exam _____ rectal exam _____ Men: genital exam _____

Women: pap & pelvic exam _____ breast exam _____

HABITS Never? How much? For how long? Quit date?

Caffeine _____ Tobacco _____

Alcohol _____ Street Drugs _____

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Name_____Date of Birth_____

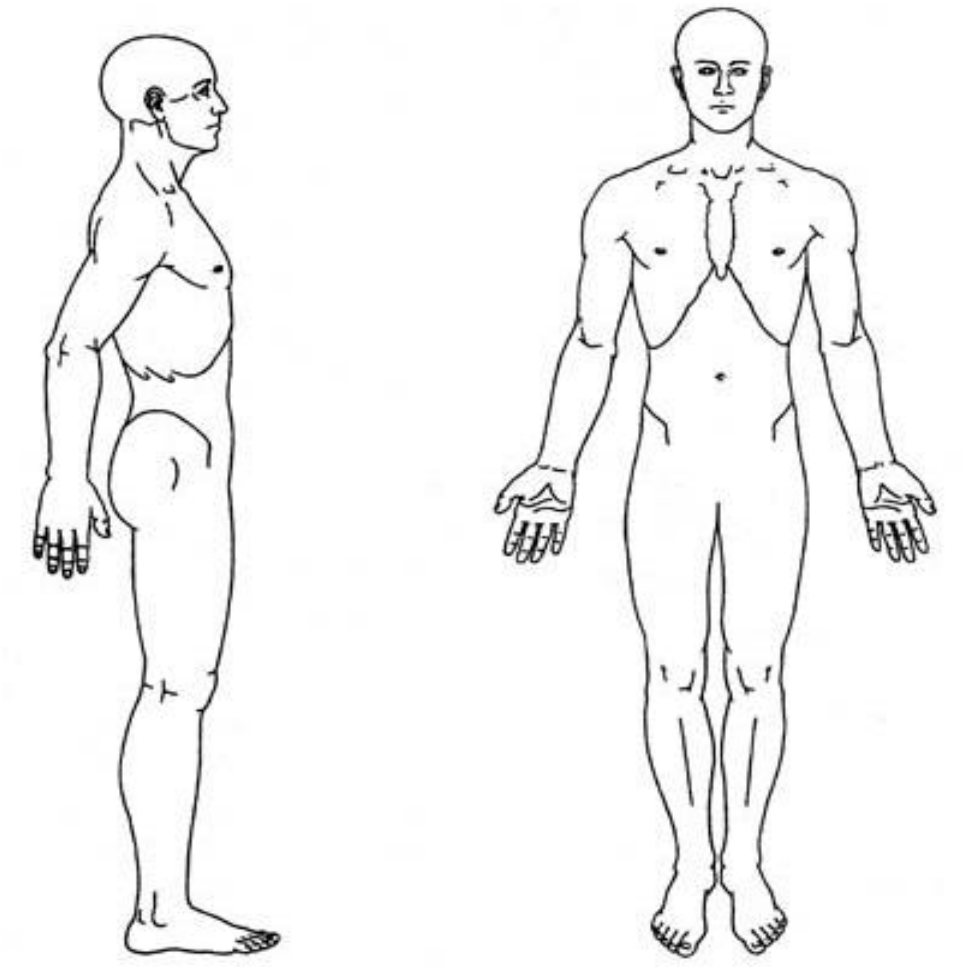
"PAIN/DISCOMFORT"

Location/Quality ***Please circle each region of symptoms and assign a letter (A through . . .) to each region of symptoms.*** Please use these letters when answering subsequent questions to indicate the region to which you are referring.

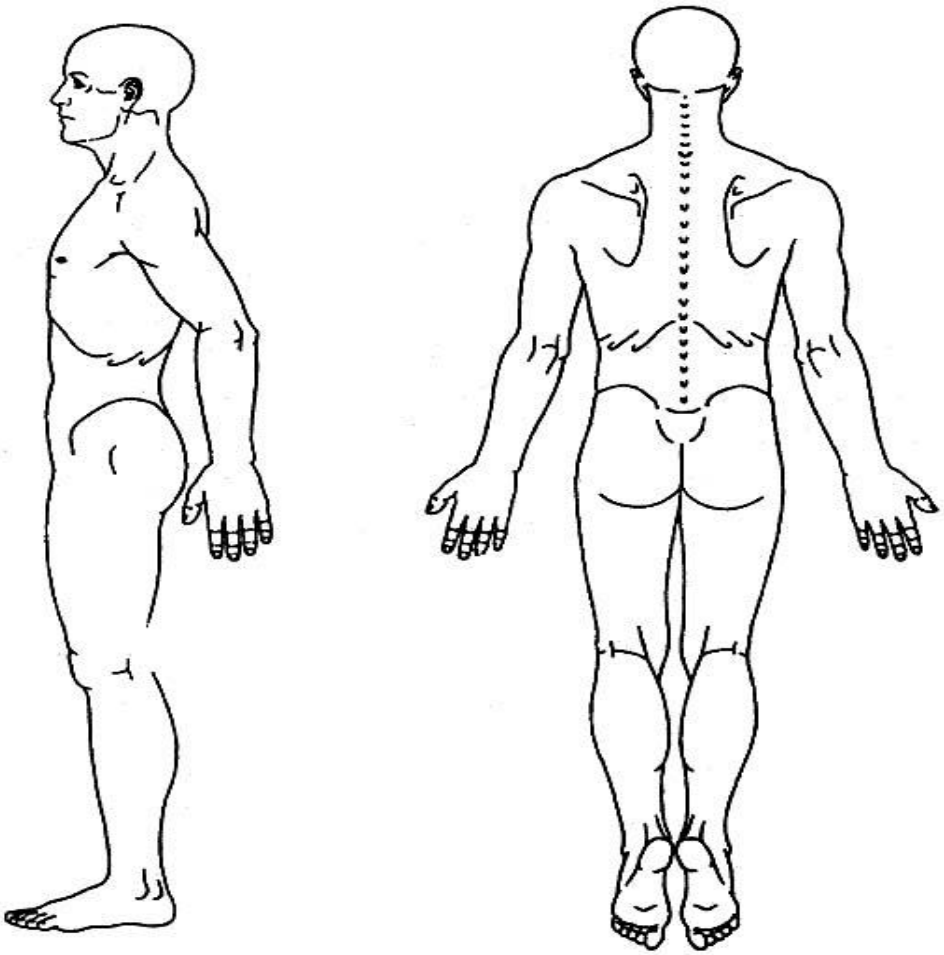
Please note the qualities of symptoms for each region using the following symbols:

stiff, tight — ++++	dull, aching — oooo	heavy — \\\\
tingling — zzzz	numb — xxxx	sickening — ====
burning — vvvv	sharp, stabbing — ////	exhausting — eeee
spasm — ssss	cramping — ^^^^	fearful — ffff
throbbing — ####	pressure — ****	gnawing — gggg
heat — hhhh	cold — cccc	boring — bbbb

Please use arrows to indicate symptoms that radiate.



Name_____Date of Birth_____



SEVERITY For each region of symptoms, please circle a number to indicate the usual severity of symptoms and an "x" through a number to indicate the severity of typical symptom flares. (Please add an additional page if more than 10 regions.)

A: (1 - No symptoms) 2 3 4 5 6 7 8 9 (10 - Worst possible severity)

B: (1 - No symptoms) 2 3 4 5 6 7 8 9 (10 - Worst possible severity)

C: (1 - No symptoms) 2 3 4 5 6 7 8 9 (10 - Worst possible severity)

D: (1 - No symptoms) 2 3 4 5 6 7 8 9 (10 - Worst possible severity)

E: (1 - No symptoms) 2 3 4 5 6 7 8 9 (10 - Worst possible severity)

F: (1 - No symptoms) 2 3 4 5 6 7 8 9 (10 - Worst possible severity)

G: (1 - No symptoms) 2 3 4 5 6 7 8 9 (10 - Worst possible severity)

H: (1 - No symptoms) 2 3 4 5 6 7 8 9 (10 - Worst possible severity)

I: (1 - No symptoms) 2 3 4 5 6 7 8 9 (10 - Worst possible severity)

J: (1 - No symptoms) 2 3 4 5 6 7 8 9 (10 - Worst possible severity)

Name_____Date of Birth_____

CHRONOLOGY/CAUSATION

When did the ***present episode*** of symptoms begin? What caused them? Sudden or gradual onset? Have they improved, worsened, or remain unchanged?

_____

_____

_____

_____

If this episode is ***not the first time in your life*** that you have experienced *this or similar* symptoms, when was? Sudden or gradual onset? Describe what initially caused the symptoms and whether the symptoms resolved, partially improved, or persisted.

_____

_____

_____

Are the ***current*** symptoms constant or intermittent? If intermittent, for how long do they last, and how frequently do they occur?_____

_____

_____

Is there a time of day / week / month / year when the current symptoms are typically better / worse?

_____

If you have an attorney helping you with a personal injury or workman's compensation claim, please indicate their name & phone #._____

_____

IMPACT

As a result of your symptoms have you been unable to work / attend school or had to change jobs? Is your job still available to you? Explain._____

_____

As a result of your symptoms have you been unable to engage or been limited in self-care, household chores, sexual relations, social / leisure / athletic activities? Describe.

_____

_____

Do you have trouble with falling? Describe._____

_____

Name_____ Date of Birth_____

PROVOCATION VS. RELIEF

Please use the letters that reference regions of symptoms! The following make the symptoms:

	Better	No change	Worse	How long are they tolerable?
Postures				
lying on back				
lying face down				
lying on right side				
lying on left side				
sitting in a straight chair				
sitting in an easy chair				
standing still				
Activities				
bending neck forward				
bending neck backward				
turning neck to the right				
turning neck to the left				
bending neck to the right				
bending neck to the left				
bending back forward				
bending back backward				
turning back to the right				
turning back to the left				
bending back to the right				
bending back to the left				
standing up from sitting				
walking				
climbing stairs				
descending stairs				
driving				
lifting				
sexual intercourse				
laughing				
chewing				
swallowing				
breathing				
Reflexes				
bowel movement				
urination				
coughing				
sneezing				
gagging				
vomiting				
orgasm				
Treatments				
heat				
cold				
traction				
stretching				
massage				
injections (trigger point)				
injections (prolotherapy/PRP)				
injections (stem cell)				
heel lifts / orthotics				
bite appliances				
Other				
fatigue				
emotional stress				
menstruation				
_____				

Name_____Date of Birth_____

Describe how *therapeutic exercise* has altered your symptoms?_____

Have you ever experienced *joint manipulation or "adjustments"* — when, why, results?

INVESTIGATIONS

List the physicians / dentists / therapists with whom you have consulted regarding your symptoms._____

Have you been told that you must learn to live with your symptoms? By whom?

Please indicate what region and the results of any of the following performed to investigate your symptoms:

"X-rays"_____

MRI scan_____

CT scan_____

Bone scan_____

Arthrogram_____

Myelogram_____

Discogram_____

Bone density scan_____

EMG (electromyogram)_____

EEG (electroencephalogram)_____

Neuropsychiatric evaluation_____

Other_____

ALLERGIES and INTOLERANCES to MEDICATIONS

Name_____Date of Birth_____

CURRENT MEDICATIONS

Include birth control pills, non-prescription medicine, & nutritional supplements. List name, amount, and timing. (Please add page(s) as necessary.) _____

LIFETIME TRAUMA HISTORY

Please list ALL **motor vehicle accidents**: when, driver or passenger, nature of collision, wearing seatbelt / shoulder harness, headrest properly positioned, part(s) of your body that impacted the car, onset of symptoms, diagnosis, treatment, resolution of symptoms? List ALL **work injuries**: when, nature of injury, onset of symptoms, diagnosis, treatment, resolution of symptoms? List ALL **major falls**: onto which area(s) of your body and what symptoms resulted. List ALL **fractures** (include nose, fingers, toes): when & how they occurred. List ALL **sprains/strains**: when & how they occurred. List ALL **alterations of consciousness** ("knocked out", "dazed", "bell rung") from physical forces: which year & cause. Have you had "the **wind knocked out of you**"? Describe which year & cause. Did or do you participate in **contact sports**? For children, describe **mother's pregnancy / labor / delivery.**

Name_____Date of Birth_____

CONCURRENT or RECENT SYMPTOMS

Explain. Note the cause, if known.

Sleep: trouble falling & / or staying asleep?_____

_____

Mood / Energy_____

Thinking / Memory_____

Dizziness / Faintness_____

Eyes / Visual_____

Ears / Hearing_____

Nasal / Sinus / Smell_____

Mouth / Dental / Taste_____

Throat / Swallowing / Speech_____

Lungs / Breathing_____

Heart / Circulation_____

Abdomen / Rectum / Digestion / Elimination_____

_____

Breasts / Genitalia / Menstruation / Erection-Ejaculation / Urination_____

_____

Extreme hunger / thirst; intolerance of heat / cold_____

Weight gain / loss Amount? Cause?_____

Skin / Hair / Other_____

FAMILY HISTORY

Do any diseases tend to “run in your family”?_____

_____

Do other members of your family have significant problems with pain?_____

_____

_____

Has there been any incidence of emotional, physical, sexual, and / or substance (drugs, alcohol, nicotine, caffeine, food) abuse in your family?_____

_____

_____

_____

Name_____ Date of Birth_____

SURGICAL & ILLNESS HISTORY *When? Why?*

Eyes / Ears_____

_____

Nose / Sinus / Mouth / Throat_____

_____

Dental: Wisdoms extracted — When? Why?_____

Braces — When?_____ Dentures?_____

Bridges?_____ Other?_____

Lungs / Heart / Circulation_____

_____

Abdomen / Rectum_____

_____

Pelvis / Genitalia_____

_____

# of Pregnancies_____ Births_____ C-sections_____

Episiotomies_____ Miscarriages_____ Abortions_____

Neurological_____

_____

Psychological_____

_____

Musculoskeletal (other than trauma related)_____

_____

Skin / Hair_____

_____

Glandular / Other_____

_____

Patient's Signature_____ **Date**_____

Physician's Signature_____ **Date**_____

The drawings on pages 2 & 3 are reproductions from: Myofascial Pain and Dysfunction - The Trigger Point Manual by Janet Travell, MD and David Simons, MD. Volume One. pp. 47 -49. Williams and Wilkins. Baltimore/London. 1983.