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 DOCTOR____

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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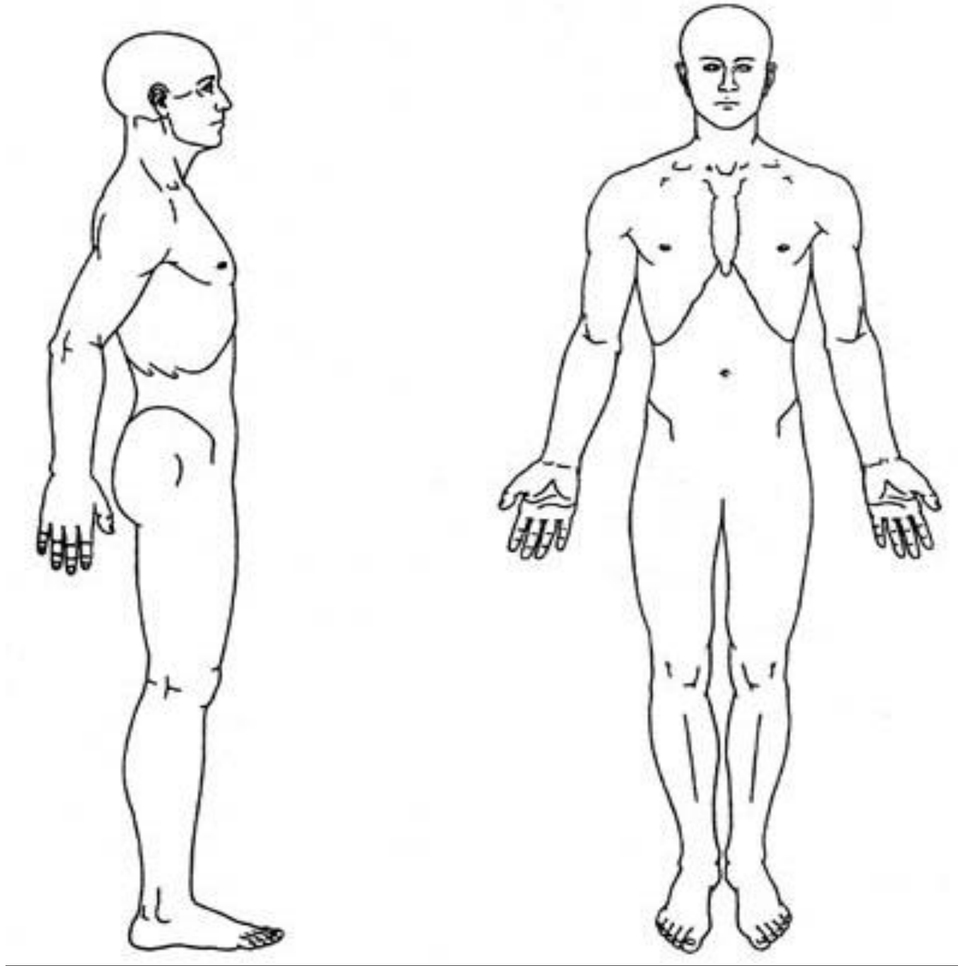
Name____________________________________Date of Birth________________

"PAIN"

Location/Quality Please mark, using the indicated symbol, the region(s) of your body where you experience the following:

tingling, pins & needles - zzzz	
dull, aching - oooo	burning - vvvv
sharp, stabbing - ////	stiff, tight - ++++
numb - xxxx	spasm - ssss
throbbing - ####	pressure - ****
heat - hhhh	cold - cccc

Please use arrows to indicate symptoms that radiate. ***Please circle and assign a number to each region of symptoms***. *Please use these numbers when answering subsequent questions to indicate the region to which you are referring.*



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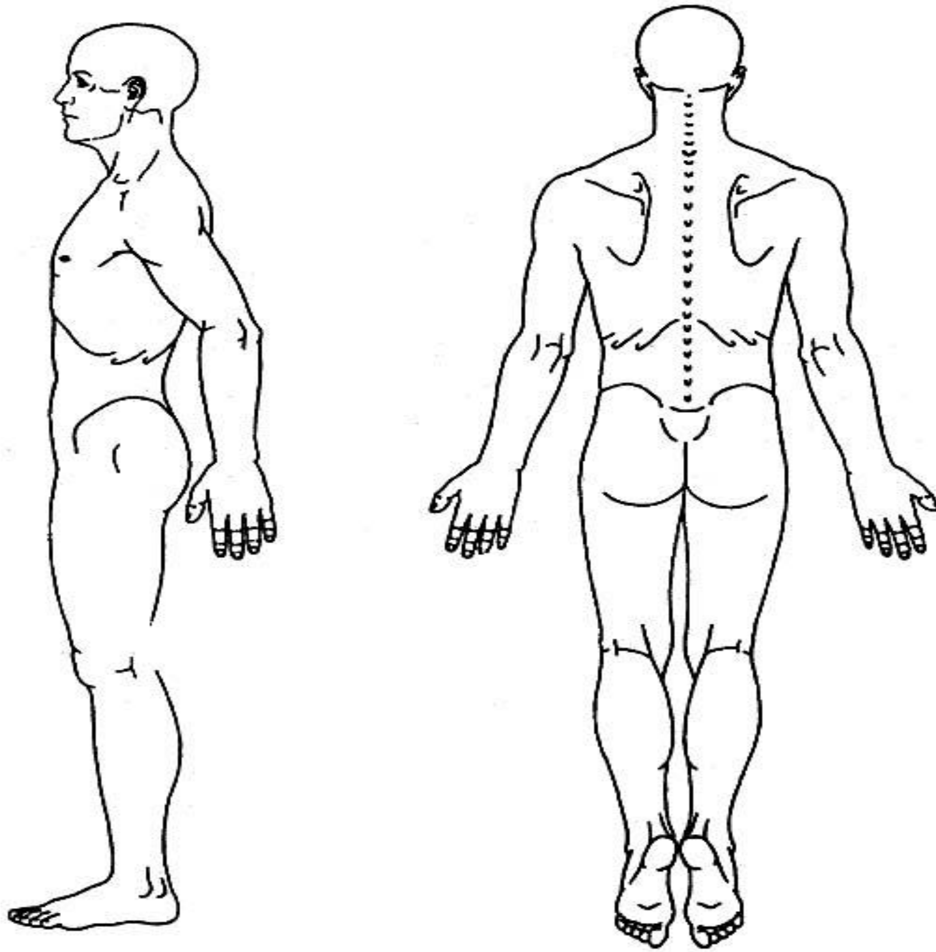
Name____________________________________Date of Birth________________



INTENSITY For each region, please circle a number to indicate the usual / average intensity of symptoms and an "x" through a number to indicate the intensity of typical flares. (Add additional page if more than 10 regions.)

#1 (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)

#2 (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)

#3 (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)

#4 (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)

#5 (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)

#6 (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)

#7 (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)

#8 (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)

#9 (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)

#10 (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)

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Name____Date of Birth_________________

CHRONOLOGY/CAUSATION

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

____

____

____

Is (Are) the current symptoms(s) constant or intermittent? If intermittent, for how long does it (do they) last and how frequently does it (do they) occur?__________________

____

____

Is there a time of day/week/month/year when it is (they are) typically better/worse?

____

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

____

____

____

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.____________________________________

____

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PROVOCATION VS. RELIEF

Please use the numbers that reference regions of symptoms!

The following make the symptoms:

	Better	No change	Worse	How long is it (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				
bending neck to the right				
bending neck to the left				
turning neck to the right				
turning neck to the left				
bending back forward				
bending back backward				
bending back to the right				
bending back to the left				
turning back to the right				
turning 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)				
injections (steroid)				
heel lifts / orthotics				
bite appliances				
Other				
fatigue				
emotional stress				
menstruation				
________________				

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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?

____

If any of the following have been performed to investigate your symptoms, indicate what region and results:

"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

____

____

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Name____Date of Birth_________________

CURRENT MEDICATIONS

Include birth control pills, non-prescription medicine, & nutritional supplements. List name, amount, and timing. (Add page 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.**

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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/Digestion/Rectum/Elimination______________________________________

____

Breasts/Menstruation/Genitalia/Urination/Sexual function________________________

____

Extreme hunger/thirst; intolerance of heat/cold_______________________________

Weight gain/loss ____

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?___________________________

____

____

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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.

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