Initial Assessment

PLEASE Select the ONE CHOICE which most closely describes your CURRENT status.

Shade bubbles like this → ●

A B C D E
Print with capital letters

Last 4 digits of SSN | First & Middle Initial | Last Name

Patient Signature

1. Gender: ○ Male ○ Female

2. Age (years): ○ 30 or under ○ 31-40 ○ 41-50 ○ 51-60 ○ 61+

3. Where is your PRIMARY problem located? (Please choose only one)
○ Neck ○ Neck with headache ○ Neck with radiating pain ○ Upper back ○ Low back
○ Low back with radiating pain below the knee ○ Other_____

4. How long ago did this episode start? ○ less than 4 weeks ago ○ 4-12 weeks ○ more than 12 weeks

5. Have you seen any other health care professionals for this episode? ○ Yes ○ No

6. Medication used for this episode?
○ None ○ Non-prescription ○ Prescription ○ Non-Prescription & Prescription

7. For this episode, how many days have you missed from work or school?
○ None ○ 1-9 days ○ 10-19 days ○ 20-29 days ○ 30-89 Days ○ 90 or more

8. Is this episode a result of an injury? ○ Yes ○ No

9. What insurance do you have for this episode?
○ Auto ○ Work Comp ○ Health ○ Other ○ None

10. Is a lawyer involved in this episode? ○ Yes ○ No

11. Besides your primary problem, are there other muscle or joint complaints? ○ Yes ○ No

12. How many times has this problem occurred before?
○ Never ○ Once ○ Twice ○ Three or more ○ Chronic Problem

13. How many spinal surgeries have you had? ○ None ○ 1 ○ 2 or more

14. In general, how would you rate your health?
○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

15. How many times have you felt depressed in the past week?
○ Not at all ○ A little ○ Some ○ A lot ○ Constantly

16. How satisfied are you with your job?
○ Extremely satisfied ○ Satisfied ○ Neither satisfied nor dissatisfied ○ Dissatisfied ○ Extremely dissatisfied

Doctor ID | State | Doctor Name | MD
Designation

After Completion - Fax to 1-303-778-0378

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