LEMONT NATURAL HEALTHCARE

1192 Walter Street., Ste. C, Lemont, IL 60439 Ph (630) 257-0550 Fax (630) 257-0555

Name: _____ Date:_____

What are your symptoms?

☐ Neck Pain ☐ Radiate L or R Arm? ☐ Headache
☐ Low Back Pain ☐ Radiate L or R Leg? ☐ Mid-Back Pain
☐ Other_____
Dr.Notes:_____
_____
_____

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Describe symptoms:

1. pain_____ numbness_____ tingling_____ stiffness _____
   burning_____ dull_____ sharp_____ aching_____ throbbing_____
   other _____
2. worsening_____ improving_____ unchanged_____
3. constant_____ frequent_____ intermittent_____ occasional_____

Dr.Notes:_____
_____

Pain Scale: (circle) No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
Dr. Notes:_____

When did your symptoms begin? Month_____ Day_____ Year_____
Dr.Notes:_____

How did your symptoms begin? ☐ suddenly ☐ gradually ☐ unknown
Dr.Notes:_____

What caused your symptoms? ☐ unknown ☐ home accident ☐ auto accident
☐ work injury ☐ sports injury ☐ other _____
Please describe:_____
Dr.Notes:_____
_____

When are your symptoms worse? ☐ morning ☐ afternoon ☐ evening

What makes your condition better? ☐ nothing ☐ rest ☐ sitting ☐ stretching
☐ exercise ☐ standing ☐ ice ☐ heat ☐ medications
☐ other _____
Dr.Notes:_____

What makes your condition worse? ☐ nothing ☐ bending ☐ coughing ☐ sneezing
☐ lifting ☐ walking ☐ sitting ☐ standing ☐ sit to stand
☐ twisting ☐ reaching ☐ changing positions ☐ turning over (bed)
☐ other _____
Dr.Notes:_____

Have you had any professional treatment for this episode? □ yes □ no
Describe: (date, doctor seen, treatment and results)

_____
_____
_____
Dr.Notes:_____
_____
_____

What does your condition prevent you from doing?
Describe: (**PLEASE BE SPECIFIC**.)

_____
_____

Have you ever had this condition before? □ no □ yes Previous episodes: 1-5 6-10 11+
Describe: (date, doctor seen, treatment and results)

_____
_____
Dr.Notes:_____
_____

What home treatments have you tried? Ice *helped* *no help* (circle one)
Heat *helped* *no help*
Medication *helped* *no help*

Other_____
Describe_____

Have you noticed a change in: bowel function □ yes □ no
bladder function □ yes □ no

Describe:_____
_____

Describe your sleep habits: Position: _____
Pillows (# , type): _____
Mattress (type, age): _____

Explain your job/employment.

_____
_____

Have you missed any work due to this condition? □ yes □ no
Is yes, please explain and give dates:

_____
_____

Is there a family history of your condition? □ yes □ no
If yes, please describe:

_____
_____

Dr._____