FORM OF PRIOR INFORMATION

Cause of the visit back trouble □ neck trouble □ arm trouble □ leg trouble □

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Profession \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from any of the following?

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Cardiovascular disease |  |  |
| High blood pressure |  |  |
| Diabetes |  |  |
| Neurological disease |  |  |
| Disease in support and movement organ |  |  |
| Respiratory disease |  |  |
| Migraine |  |  |
| Rheumatism |  |  |
| Thyroid disease |  |  |
| Malignant tumor |  |  |
| Problems with mental health / stress |  |  |
| Allergy |  |  |
| Osteoporosis |  |  |
| Other common disease |  |  |

Have you during the last two weeks felt?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes | No |  | Yes | No |
| Fever |  |  | Weigh loss |  |  |
| Deterioration in general condition |  |  | Chest pain on effort |  |  |
| Pain when breathing |  |  | Dizziness |  |  |
| Persistent headache |  |  | Trouble with stomach |  |  |
| Infection disease |  |  | Incontinence/urinary retention |  |  |
| Loss of strength in the extremities |  |  | Pain in testicles |  |  |
| Radiating pain in arms/legs |  |  |  |  |  |

Do you smoke? Yes No

Are you pregnant? Yes No

How often do you exercise/form of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use regular medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been in an accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it the first time you experience the current pain/current trouble? Yes No

Have X-rays/MRI been made for the current pain/trouble Yes No

Have you undergone surgery for the actual pain or some other reason? Yes No

How long has the current pain/trouble lasted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you think caused the current pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What painkillers have you been taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which movements/positions cause the most pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which movements/positions relieve the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How much pain have you experienced on an average, during the last 2 days? Put a mark arround the number that best describes the intensity of your pain.

no pain at all 0\_\_\_1\_\_\_2\_\_\_3\_\_\_4\_\_\_5\_\_\_6\_\_\_7\_\_\_8\_\_\_9\_\_\_10 worst possibel pain

Your ability to work is 10 at the best. Put a mark around the number to describe your work ability.

No work ability 0\_\_\_1\_\_\_2\_\_\_3\_\_\_4\_\_\_5\_\_\_6\_\_\_7\_\_\_8\_\_\_9\_\_\_10 Your work ability at it´s best

PAIN CHART

Draw in the are of the

current pain with XXX

numbness with ///

insensibility OOO

tightness in muscles +++

burning sensation ZZZ