****Please use ink ONLY****

2835 McFarland Rd, STE D
Rockford, IL 61107
P: 1-855-815-PAIN
info@nextlevelhealth.com

PATIENT NAME:

Name:_____ Birth Date: _____-_____-_____

Age: _____ Male / Female

Height:_____Weight:_____

Address: _____ City: _____

State: _____ Zip: _____E-mail Address: _____

Cell Phone: _____Home Phone:_____

Marital Status: ☐Single ☐Married ☐Significant Others' Name:_____

Occupation:_____Employer: _____

Children and Ages:_____

Name & Number of Emergency Contact: _____ Relationship: _____

Driver's License #: _____Social Security #:_____-_____-_____

Do you have insurance YES / NO Name of Insurance:_____Policy# #_____

(Please present your Health Insurance Card as well as Driver's License or State ID to front desk staff)

WHAT BRINGS YOU IN?

Please identify the condition(s) that brought you in:	Level of Pain or Symptoms
Primary:	0- 1- 2- 3– 4–5– 6– 7– 8– 9– 10
Secondary:	0- 1- 2- 3– 4–5– 6– 7– 8– 9– 10
Third:	0- 1- 2- 3– 4–5– 6– 7– 8– 9– 10
Fourth:	0- 1- 2- 3– 4–5– 6– 7– 8– 9– 10

When did the problem(s)begin?_____

How did the injury happen?_____ ☐Auto ☐Work ☐Unknown ☐Insidious ☐Trauma ☐Slow Progression

When is the problem at its worst? ☐AM ☐PM ☐mid-day ☐Evening PM ☐ While Working

Did you notice pain immediately after accident or trauma? Yes / No

Did you notice ☐PAIN ☐NUMBNESS ☐TINGLING☐ WEAKNESS ☐SPASM in either Leg, Arm or Hand? Yes / No

What relieves your symptoms? _____What makes them feel worse?_____

When do you experience your problem(s):☐Constant ☐Intermittent ☐Occasionally ☐Comes and Goes ☐Rarely

Is it painful when you are getting up and down? Yes / No Doesn't Apply

Does pain decrease with use of Ice or Heat? Yes / No Doesn't Apply

Have symptoms changed since onset(circle one): Better Same Worse

HEADACHES: What Type(s)? Tension Migraines Postural Medication Affects Hormonal Other

How often: ☐Daily ☐1-2x per week ☐3-4x per week ☐5-6x per week ☐Occasionally ☐Never

Where are they located? (check all that apply)

☐Front ☐Back ☐ Right Side ☐Left Side ☐Top of Head ☐Ocular ☐Other:_____

When do they occur? (circle) Mornings Afternoons Evenings Nights Working

Are your Headaches related to your present Accident, Injury, Trauma, or illness? Yes / No

Do any of these symptoms accompany your headaches? (circle all that apply)

Nausea Vomiting Dizziness Passing Out Blurry Vision Other:_____

PATIENT NAME: _____ DATE:_____

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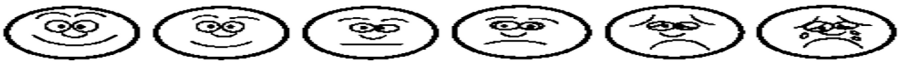
Neuropathy | Physical | Regenerative Medicine

❑ **HEAD – Headache**
Occiput – C0 – Skull
Sinuses – EARS
Post Trauma

MIGRAIN| TENSION | | SPASM | SINUS| BACK | FRONT | TEMPLE RT / LFT



Severity? 0 1 2 3 4 5 6 7 8 9 10
When? Occasional | Comes and Goes | Less Frequent | Frequent | Constant

How Are You?
❑Same
❑Better
❑As Expected
❑Worse

❑ **NECK - Neckache**
Cervical C1-C7
Upper Neck

PAIN | TENSION | Trigger Pts | SPASM | STIFF| ACHE | NERVE | | RADIATING

Severity? 0 1 2 3 4 5 6 7 8 9 10
When? Occasional | Comes and Goes | Less Frequent | Frequent | Constant

❑Same
❑Better
❑As Expected
❑Worse

❑ **MID-UPPER BACK**
Thoracic T1-T12
Between Shoulder(s)
Shoulder(s)

PAIN | TENSION | Trigger Pts | SPASM | STIFF| ACHE | NERVE | | RADIATING

Severity? 0 1 2 3 4 5 6 7 8 9 10
When? Occasional | Comes and Goes | Less Frequent | Frequent | Constant

❑Same
❑Better
❑As Expected
❑Worse

❑ **LOW BACK - HIPS**
Lumbar L1-L5
Pelvis – Sacrum - IL
HIP(s) Glut(s) RT / LFT

PAIN | TENSION | Trigger Pts | SPASM | STIFF| ACHE | SCIATICA | | RADIATING

Severity? 0 1 2 3 4 5 6 7 8 9 10
When? Occasional | Comes and Goes | Less Frequent | Frequent | Constant

❑Better
❑Same
❑Worse
❑As Expected

❑ **UPPER EXTREMITY**
RT – LFT - BOTH
SHOULDERS | ELBOWS
WRIST | HANDS | DIGITS

WEAK | Restricted | SPASM | STIFF| ACHE | NERVE | NUMB | RADIATING

Severity? 0 1 2 3 4 5 6 7 8 9 10
When? Occasional | Comes and Goes | Less Frequent | Frequent | Constant

❑Same
❑Better
❑As Expected
❑Worse

❑ **LOWER EXTREMITY**
RT – LFT - BOTH
HIP(S) LEG(S) KNEE(S)
ANKLE – FEET - TOES

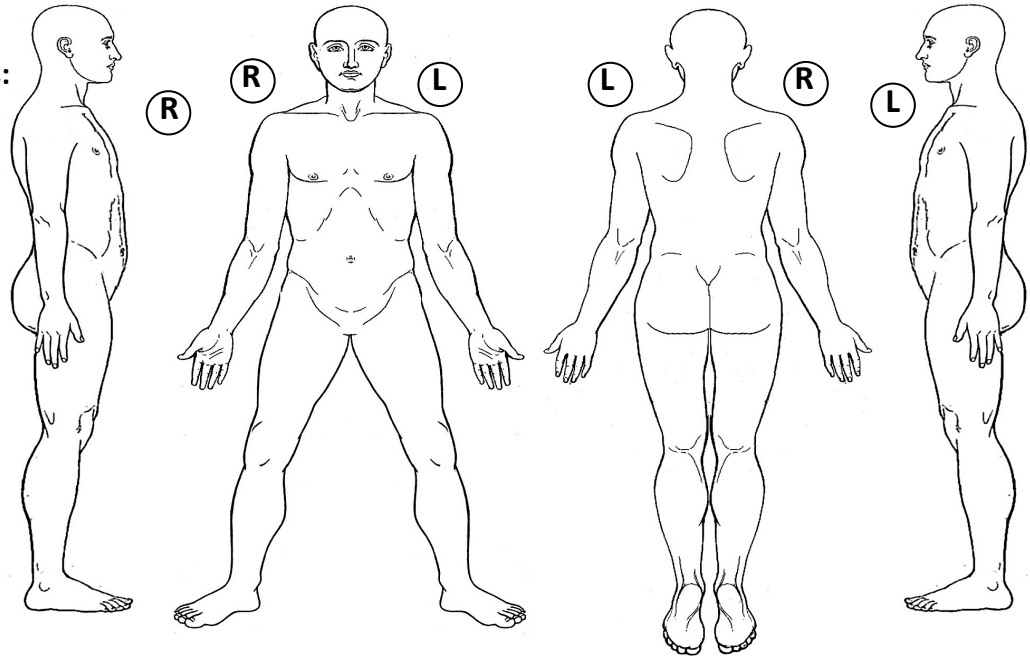
WEAK | Restricted | SPASM | STIFF| ACHE | NERVE | NUMB | RADIATING

Severity? 0 1 2 3 4 5 6 7 8 9 10
When? Occasional | Comes and Goes | Less Frequent | Frequent | Constant

❑Same
❑Better
❑As Expected
❑Worse

On the diagram, please mark using the letters:

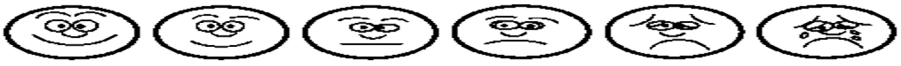
P = Pain
A = Ache
B = Burning
S = Stabbing
D = Dull Pain
R = Radiating
H = Throbbing
N = Numbness
T = Tingling



Doing Home Care?
❑None
❑As Instructed
❑1x – 2x
❑3x – 4x
Daily or Weekly

Additional Notes:

PATIENT NAME: _____ DATE:_____



How Are You?
- ❑Same
- ❑Better
- ❑As Expected
- ❑Worse

❑ **KNEE(S)**
RT – LFT – BOTH

Severity? 0 1 2 3 4 5 6 7 8 9 10

WEAK | Restricted | TENDONITIS | STIFF| ACHE | NERVE | NUMB | RADIATING

When? Occasional | Comes and Goes | Less Frequent | Frequent | Constant

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❑ **CALVES - ANKLES**
RT – LFT – BOTH

PAIN | TENSION | Trigger Pts | SPASM | STIFF| ACHE | NERVE | | RADIATING

Severity? 0 1 2 3 4 5 6 7 8 9 10

When? Occasional | Comes and Goes | Less Frequent | Frequent | Constant

- ❑Same
- ❑Better
- ❑As Expected
- ❑Worse

❑ **FEET - TOES**
RT – LFT – BOTH

PAIN | TENSION | BURN | PLANTAR | STIFF| ACHE | NERVE | | RADIATING

Severity? 0 1 2 3 4 5 6 7 8 9 10

When? Occasional | Comes and Goes | Less Frequent | Frequent | Constant

- ❑Same
- ❑Better
- ❑As Expected
- ❑Worse

❑ **SHOULDER(S)**
RT – LFT – BOTH
BLADES - ROTATORS

PAIN | TENSION | Trigger Pts | SPASM | STIFF| ACHE | SCIATICA | | RADIATING

Severity? 0 1 2 3 4 5 6 7 8 9 10

When? Occasional | Comes and Goes | Less Frequent | Frequent | Constant

- ❑Better
- ❑Same
- ❑Worse
- ❑As Expected

❑ **ELBOW(S)**
RT – LFT – BOTH
FORARMS

WEAK | Restricted | TENDONITIS | STIFF| ACHE | NERVE | NUMB | RADIATING

Severity? 0 1 2 3 4 5 6 7 8 9 10

When? Occasional | Comes and Goes | Less Frequent | Frequent | Constant

- ❑Same
- ❑Better
- ❑As Expected
- ❑Worse

❑ **WRISTS – HANDS**
RT – LFT – BOTH
FINGERS 1 – 2- 3 - 4 - 5

WEAK | Restricted | CARPAL | STIFF| ACHE | NERVE | NUMB | RADIATING

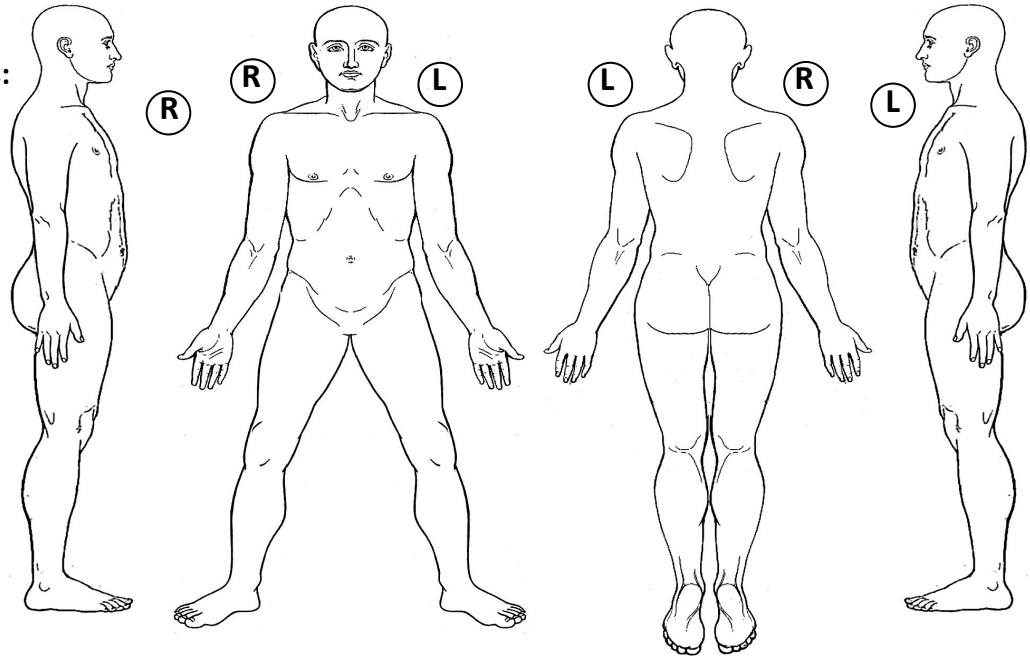
Severity? 0 1 2 3 4 5 6 7 8 9 10

When? Occasional | Comes and Goes | Less Frequent | Frequent | Constant

- ❑Same
- ❑Better
- ❑As Expected
- ❑Worse

On the diagram, please mark using the letters:

P = Pain
A = Ache
B = Burning
S = Stabbing
D = Dull Pain
R = Radiating
H = Throbbing
N = Numbness
T = Tingling



Doing Home Care?
- ❑None
- ❑As Instructed
- ❑1x – 2x
- ❑3x – 4x

Daily or Weekly

Additional Notes:

If you have a Family History listed please circle "**F**" for that symptom in the ***Family*** Column.

If you have had a listed symptom in the Past, please circle **"P"** in the ***Past*** Column.

If you are currently having a particular symptom, circle the **"C"** for that symptom in the ***Current*** Column.

Family	Past	Current		Family	Past	Current	
F	P	C	Abdominal Pain	F	P	C	Nausea
F	P	C	Abnormal Weight: Gain / Loss	F	P	C	Low Back Pain
F	P	C	Allergies / Sinusitis	F	P	C	Mid-Back Pain
F	P	C	Angina	F	P	C	Muscular In-coordination
F	P	C	Ankle(s) Pain	F	P	C	Neck Pain or Stiffness
F	P	C	Anorexia	F	P	C	Numbness (where):
F	P	C	Aortic Aneurysm	F	P	C	Muscle Spasm (where):
F	P	C	Arm(s) Pain (Right – Left – Both)	F	P	C	Pain in Ankle or Foot (Right – Left – Both)
F	P	C	Arthritis	F	P	C	Pain in Lower Leg or Knee (Right – Left – Both)
F	P	C	Asthma	F	P	C	Pain in Upper Arm or Elbow (Right – Left – Both)
F	P	C	Back Pain	F	P	C	Pain in Upper Leg or Hip (Right – Left – Both)
F	P	C	Bladder Problems	F	P	C	Painful Urination
F	P	C	Blood Disorder	F	P	C	Plantar Fascitis
F	P	C	Breast: Soreness / Lumps	F	P	C	PMS
F	P	C	Cancer, Explain:	F	P	C	Profuse Menstrual Flow
F	P	C	Carpal Tunnel	F	P	C	Prostate Problems
F	P	C	Chest Pains	F	P	C	Radiculitis
F	P	C	Chronic Cough	F	P	C	Rapid Heart Beat
F	P	C	Chronic Sinusitis	F	P	C	Restless Legs
F	P	C	Colitis	F	P	C	Rheumatoid Arthritis
F	P	C	Constipation / Irregular bowel habits	F	P	C	Sciatica
F	P	C	Convulsions	F	P	C	Scoliosis
F	P	C	Diabetes	F	P	C	Shoulder Pain
F	P	C	Depression	F	P	C	Sleep Apnea
F	P	C	Dermatitis / Eczema / Rash	F	P	C	Sleep Problems
F	P	C	Difficulty in Swallowing	F	P	C	Stroke (Date):
F	P	C	Dizziness	F	P	C	Stiffness (where):
F	P	C	Ear Problems or Pain	F	P	C	Swelling, Stiffness of Joint(s)
F	P	C	Elbow Pain (Right – Left – Both)	F	P	C	Thyroid Problem
F	P	C	Emphysema (chronic lung disorders)	F	P	C	Tinnitus (Ear Noises)
F	P	C	Endometriosis	F	P	C	Tumor, Explain:
F	P	C	Epilepsy	F	P	C	Ulcer
F	P	C	Erectile Dysfunction or Impotence	F	P	C	Vertigo
F	P	C	Excessive Thirst	F	P	C	Visual Disturbances
F	P	C	Fainting	F	P	C	Vommiting
F	P	C	Frequent Urination	F	P	C	Wrist Pain
F	P	C	Fybromyalgia	F	P	C	Whiplash
F	P	C	Gallbladder Problems	F	P	C	Other:
F	P	C	General Fatigue				**Have You or Your Family Had:**
F	P	C	Hand Pain (Right – Left – Both)	F	P	C	Cancer
F	P	C	Headhaches or Migraines	F	P	C	Chronic Back Problems
F	P	C	Heart Attack (when):	F	P	C	Chronic Headaches
F	P	C	Heartburn / Indigestion	F	P	C	Diabetes
F	P	C	High Blood Pressure	F	P	C	Epilepsy
F	P	C	Incontinence	F	P	C	Heart Problems
F	P	C	Irregular Menstrual Flow	F	P	C	High Blood Pressure
F	P	C	Irritable Colon	F	P	C	Lung Problems
F	P	C	Jaw Pain or TMJ	F	P	C	Lupus
F	P	C	Kidney Disorder	F	P	C	Rheumatioid Arthritis
F	P	C	Kidney Stones	F	P	C	Stroke
F	P	C	Knee Pain (Right – Left – Both)				**Social and Habit History**
F	P	C	Liver Problems		P	C	Tobacco use packs/tins per day
Please list Current Medication(s):					P	C	Alcohol use drinks per day / week / month
					P	C	Drug or Alcohol Dependence
					P	C	Caffein Drinks per day
					P	C	Exercise or Fitness minutes per day / week

Please list Hospitalizations / Surgeries Please describe:

ABILITY CHART

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PLEASE USE INK ONLY

Having pain can make the simplest everyday task difficult. It can be hard to explain to your health care professional how climbing stairs, getting out of a chair, or bathing might be challenging. This tool will help you to identify all the areas where you struggle and how much trouble you have with each item. **Simply circle your level of difficulty. 0 means not difficult at all and 10 means it is extremely difficult for you to accomplish**.

Pain Level

0 1 2 3 4 5 6 7 8 9 10

No Pain — Extreme Pain

Getting Out of Bed

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Climbing Stairs

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Descending Stairs

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Getting Out of a Chair

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Walking

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Personal Care

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Daily Activity

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Working

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Leisure Activities

0 1 2 3 4 5 6 7 8 9 10

No Difficulty — Extreme Difficulty

Quality of Life

0 1 2 3 4 5 6 7 8 9 10

Excellent — Poor

ACTIVITIES OF DAILY LIVING / ENJOYMENT OF LIFE

Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Other (please describe):_____

_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this Doctor immediately whenever I have changes in my health condition

I hereby authorize payment to be made directly to NEXT LEVEL MEDICAL CENTER PLLC, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to NEXT LEVEL MEDICAL CENTER PLLC for any and all services I receive at this office.

_____ _____/_____/ 20____

Patient or Authorized Person's Signature **Date Completed**

_____ _____/_____/ 20____

Staff Witness Signature **Date Form Reviewed**