Patient Name:________________________________**DOB:**___________**Today's Date:**________________

CHIEF COMPLAINT: Briefly state what issue you would like me to address today?________________________________

HISTORY OF PRESENT ILLNESS:

1. START & CIRCUMSTANCES OF PAIN- When did pain start and what was the cause? (motor vehicle accident, fall, sports injury, etc.)

2. LOCATION- Where is the majority of your pain?

3. QUALITY- What kind of pain are you having? Please check [√] all that apply.

□ Burning □ Pins & Needles □ Electric □ Dull Aching
□ Numbness □ Aching □ Stabbing □ Shooting □ Other

4. DURATION/TIMING- Describe your pain pattern and time when it occurs. Please [√] check all that apply.

□ Morning □ Mid-Day □ Evening □ Night
□ Intermittent □ Continuous □ Sporadic

5. SEVERITY- On a scale of 1 to 10, place the number of the level of the pain on the lines below

What is your pain level **TODAY?** ______________ What is your **LEAST** level of pain? ______________ What is your **WORST** level of pain? ______________

6. Which is worse? Please circle one. Back/Neck Pain or Leg/Arm Pain

7. Please list any associated signs and symptoms- (numbness/weakness/blurred vision)

____

8. What does you pain prevent you for doing? (sleeping/house or yard work/recreational activities/job duties)

____

9. MODIFYING FACTORS- Please indicate any of the following treatments you have had by checking [√] the effect

TREATMENT	HELPED	MADE WORSE	NO EFFECT
Hot Packs			
Ultrasound			
Ice			
Massage			
TENS Unit			
Back School			
Strengthening Exercises			
Aerobics (exercise, bike, etc.)			
Traction			
Bed Rest			
Chiropractic Treatment			
Trigger Point Injections			
Epidural Injections			
Facet Injections			
Back Brace			
Acupuncture			
Anti-Inflammatory Medications			
Narcotic Pain Medication			
Muscle Relaxant Medication			
Anti-Depressant Medication			

HT________ WT________ BP ____________ P______ R________ T______

REVIEWS OF SYSTEM- PLEASE CHECK [√] ALL THAT APPLIES.

GENERAL
- □ Fever
- □ Weight Loss
- □ Fatigue

RESPIRATORY
- □ Asthma
- □ COPD
- □ Emphysema
- □ Cough

SKIN
- □ Skin Breakout
- □ Rash
- □ Burns
- □ Skin Grafts

EYE,EAR,NOSE,THROAT
- □ Blurry Vision
- □ Glaucoma
- □ Cataracts
- □ Dental Procedure last week
- □ Hearing Difficulty
- □ Swallowing Difficulty
- □ Speech Difficulty

GASTROINTESTINAL
- □ Ulcers
- □ Reflux
- □ Liver Disorder
- □ Blood in Stool
- □ Hiatal Hernia
- □ Bowel Leakage/intontinence

CARDIOVASCULAR
- □ Heart Disease
- □ Angina
- □ Pacemaker
- □ Irregular Heart Beat
- □ High Blood Pressure
- □ Cardiac Stents

ENDOCRINE
- □ Diabetes
- □ Thyroid Disorder

BLOOD/LYMPHATIC
- □ Bleeding/Bruising disorder
- □ Blood Clots/PE
- □ Anemia
- □ Anticoagulated/blood thinner

PSYCHIATRIC
- □ Depression
- □ Anxiety
- □ Mood Swings

GENITOURINARY
- □ Prostate Problems
- □ Kidney Stones
- □ Bladder Infections
- □ Incontinence

MUSCULOSKELETAL
- □ Arthritis
- □ Muscle pain
- □ Joint pain

(location)

NEUROLOGIC
- □ Memory Loss
- □ Sensory Loss
- □ Weakness
- □ Coordination
- □ Falls

ALLERGIES

Do you have any of the following allergies? Please check [√] all that applies.

□ Shellfish □ Iodine □ Steroids □ Local Anesthetics (i.e. idocaine)

Please List any allergies you have to medications and the reaction.

MEDICAL AND SURGICAL HISTORY

Please list active medical problems and the physician following you for the problem.

Please list past surgical procedures including date and physician who performed the procedure.

____

Preferred Pharmacy:____

Pharmacy Phone:________________________ **Phamacy Address:**___________________

MEDICATIONS

Please list all of the medications that you are currently taking:

____
____
____
____
____

FAMILY HISTORY

Mother: □ Living □ Deceased, Due to:_________________________Age:_____

Father: □ Living □ Deceased, Due to:_________________________Age:_____

Siblings: □ Living □ Deceased, Due to:_________________________Age:_____

Please check [√] any of the following conditions that run in your family:

□ Headaches	□ Migraines	□ Arthritis	□ Neck/Back Pain
□ Fibromyalgia	□ Lupus	□ Drug Dependency	□ Drug Abuse
□ Anxiety	□ Schizophrenia	□ Suicide	□ Depression
□ Alcoholism			

SOCIAL HISTORY

Do you drink alcohol? □ Yes □ No If yes, how much and how often?__________________

Do you smoke? □ Yes □ No If yes, how much and how often?__________________

Do you use drugs? □ Yes □ No If yes, what type and how much?__________________

Are you married? □ Yes □ No □ Other (divorced, widowed, etc)__________________

Do you have children? □ Yes □ No If yes, How many?_____________________________

Please list any hobbies:____

Do you work? □ Yes □ No Occupation (present or former)____________________

Board Certified Neurologists and Neurosurgeons
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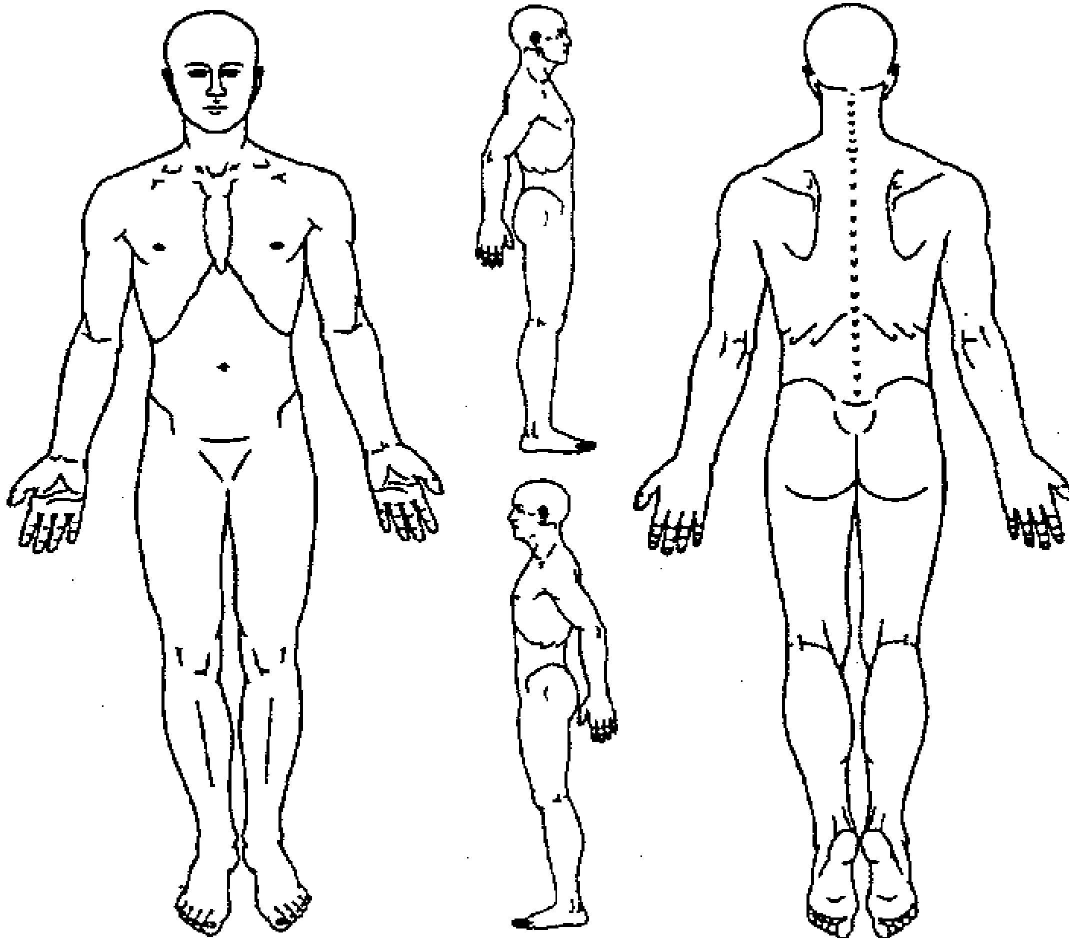
Physical Medicine and Rehabilitation Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



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