

Patient Information

Today's date: _____

Your name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

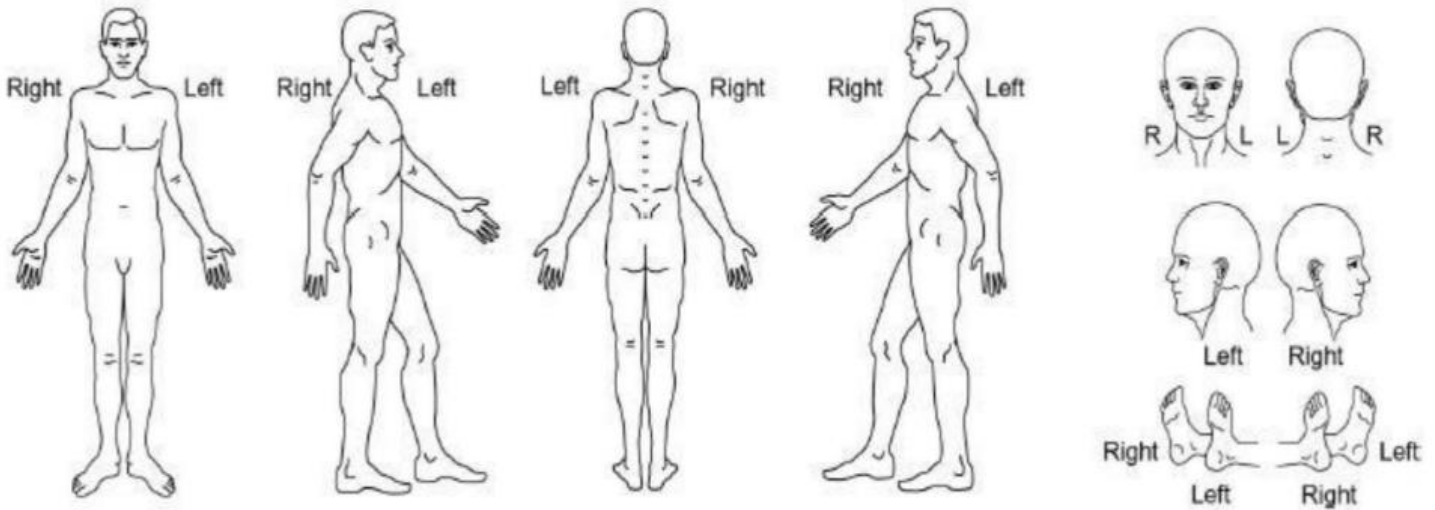
Pain History

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so where? _____

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? Gradually Suddenly

Since your pain began how has it changed? Improved Worsened Stayed the same

Pain Description

Check all of the following that describe your pain:

- | | | | |
|--------------------------------------|--|-----------------------------------|---|
| <input type="checkbox"/> Dull/Aching | <input type="checkbox"/> Hot/Burning | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stabbing/Sharp |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Numbness | <input type="checkbox"/> Spasming | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Squeezing | <input type="checkbox"/> Tingling/Pins and Needles | | <input type="checkbox"/> Tightness |

When is your pain at its worst?

- | | | | |
|--|----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Mornings | <input type="checkbox"/> Daytime | <input type="checkbox"/> Evenings | <input type="checkbox"/> Middle of the night |
| <input type="checkbox"/> Always the same | | | |

How often does the pain occur?

- | | |
|--|---|
| <input type="checkbox"/> Constant | <input type="checkbox"/> Changes in severity but always present |
| <input type="checkbox"/> Intermittent (comes and goes) | |

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now _____ The Best It Gets _____ The Worst It Gets _____

Mark the effect each of the following have on your pain level -

	Increases	Decreases	No Change
Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in Weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking upward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking downward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from seated position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What other factors worsen or affect your pain which is not mentioned above?

Associated Symptoms

	NO	Yes	Comments
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Where? _____
Weakness in the arm/leg	<input type="checkbox"/>	<input type="checkbox"/>	_____
Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fevers/chills	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please mark all of the following treatments you have used for pain relief:

	No Change	Worsened Pain	Helped Pain
Spine Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brace Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot/Cold Packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

Interventional Pain Treatment History

- Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar
- Joint Injection – Joint(s) _____
- Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar
- MILD (Minimally Invasive Lumbar Decompression) - _____
- Nerve Blocks – Area/Nerve(s) - _____
- Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar
- Spinal Cord Stimulator – Trial Only/Permanent Implant _____
- Trigger Point Injections – Where? _____
- Vertebroplasty/Kyphoplasty – Level(s) _____
- Other - _____

Which of these procedures listed above have helped with your pain? _____

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

- MRI of the: _____ Date: _____
- X-Ray of the: _____ Date: _____
- CT Scan of the: _____ Date: _____
- EMG/NCV study of the: _____ Date: _____
- Other Diagnostic Testing: _____ Date: _____
- I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

- | | | |
|--|---|--|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Psychiatrist/Psychologist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Orthopedic Surgeon | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Internist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Neurologist |
| <input type="checkbox"/> Other _____ | | |

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

- 1) _____ Date? _____
- 2) _____ Date? _____
- 3) _____ Date? _____
- 4) _____ Date? _____
- 5) _____ Date? _____

I have **NEVER** had any surgical procedures performed.

Current Medications

Are you currently taking any blood thinners or anti-coagulants? YES No

If **YES**, which ones? Aspirin Plavix Coumadin Lovenox Other _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____
9)	_____	_____	_____
10)	_____	_____	_____

Please list all past pain medications that you have been on at any point for your current pain complaints?

	<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

Allergies

Do you have any drug/medication allergies? Yes No

If so, please list all medications you are allergic to:

<u>Medication Name</u>	<u>Allergic Reaction</u>
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Topical Allergies: Latex Iodine Tape IV Contrast

Family History

Mark all appropriate diagnoses as they pertain to your first degree relatives:

- Arthritis Cancer Diabetes
- Headaches/Migraines High Blood Pressure Kidney Problems
- Liver Problems Osteoporosis Rheumatoid arthritis
- Seizures Stroke
- Other Medical Problems: _____
- I have no significant family medical history

Social History

Occupation: _____ When was the last time you worked? _____

Who is in your current household? _____

Are there any stairs in your current home? _____ If so how many? _____

Temporary Disability Permanent Disability Retired Unemployed

Are you currently under worker's compensation? No Yes

Is there an ongoing lawsuit related to your visit today? No Yes

Alcohol Use:

- Social Use History of alcoholism Current alcoholism Never
- Daily use of alcohol

Tobacco Use:

- Current user Former user Never used
- Packs per day? _____ How many years? _____ Quit Date: _____

Illegal Drug Use:

- Denies any illegal drug use Currently uses illegal drugs
- Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications? Yes No