

Patient Name _____ Date of Birth _____ Age _____
 Gender: (Please circle) Male / Female Race: (Please circle) White / Black / Hispanic / Asian / Other _____

Who referred you to us? _____ Who is your Family Doctor? _____
 Is your visit related to an injury? YES/NO If Yes, specify: AUTO Work Comp OTHER
 Have you been to any previous pain management? Yes or No (circle one)
 Name of Physician(s) _____

WORK STATUS: _____ Regular Duty _____ Light Duty, Restrictions _____
 _____ Off Work: last worked: _____
 _____ Disabled: since _____ by what doctor _____
 _____ Retired: since what year _____

Location of Pain: _____

In the diagram below, please shade the areas of your pain

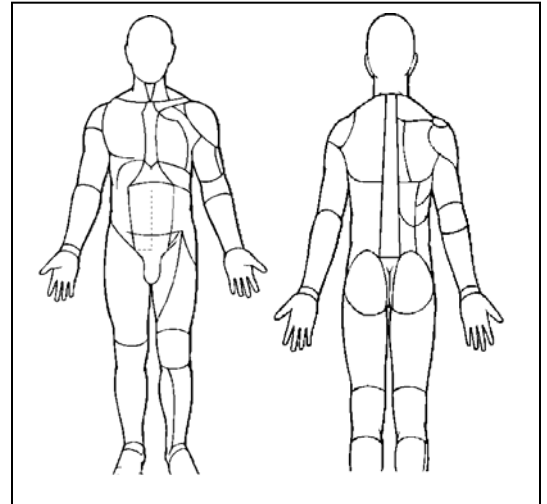
(Circle your answer)

Pain Scale: From 0 - 10 what is your pain level today?
 (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

What is your range of pain in the past month?
 (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

What treatments have you had for your pain? Check all that apply.

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Favorable Results | <input type="checkbox"/> Poor Results |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Favorable Results | <input type="checkbox"/> Poor Results |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Favorable Results | <input type="checkbox"/> Poor Results |
| <input type="checkbox"/> Trigger Point Injections | <input type="checkbox"/> Favorable Results | <input type="checkbox"/> Poor Results |
| <input type="checkbox"/> TENS Unit | <input type="checkbox"/> Favorable Results | <input type="checkbox"/> Poor Results |
| <input type="checkbox"/> Nerve Blocks | <input type="checkbox"/> Favorable Results | <input type="checkbox"/> Poor Results |
| Type of Nerve Block _____ | | |



- | | | |
|---|------------|----------------------|
| <input type="checkbox"/> Back or Neck Surgery | Type _____ | When _____ |
| <input type="checkbox"/> Spinal Cord Stimulator | Type _____ | Date implanted _____ |
| <input type="checkbox"/> Morphine Pump | Type _____ | Date implanted _____ |
| <input type="checkbox"/> Other: _____ | | |

Allergies: _____

Patient History: (check each that apply)

- Tobacco: do not smoke smoke pack(s) per day
 Alcohol: do not drink drink # of drinks per day week
 Social History: Married Single Divorced
 Lives With: Spouse Children Other Alone
- Blind Glasses Contacts Hard of Hearing Deaf HIV+
 Hearing Aids Cancer Thyroid Disease Gallbladder Disease Birth Defects



Under each Category, please check any symptoms that apply

Cardiovascular

- ___Hypertension (High)
___Hypotension (Low)
___Anemia
___Heart Disease
___Stroke
___Swelling of Feet
___Chest Pain
___Shortness of Breath
___Rheumatic Fever

Gastrointestinal

- ___Chronic Diarrhea
___Chronic Constipation
___Incontinence
___Ulcers
___Hepatitis
___Ulcers
___Liver Disease
___Diabetes
___Gout
___Other:_____

Neurological

- ___Migraines
___Frequent Headaches
___Epilepsy
___Sleeping Disorders
___Restless Leg Syndrome
___Other:_____

Musculoskeletal

- ___Arthritis
___Osteoarthritis
___Rheumatoid
___Low Back Syndrome
___Cane
___Walker
___Wheelchair
___Prosthesis
Type:_____
___Other:_____

Psychiatric

- ___Depression
___Anxiety Disorder
___Bipolar
___Alcoholism
___Drug Addiction
___Suicide Attempt
___Schizophrenia
___Other:_____

Genitourinary:

- ___Urinary Incontinence
___Kidney Disease
___Other:_____

Respiratory:

- ___Asthma
___COPD
___Chronic Cough
___O2 Therapy

Medications you are presently taking: Include Over the Counter & prescription drugs.

Pain Medications, Muscle Relaxants, Sleep Aid, Anti-anxiety, and Antidepressants.

Medications Dose Frequency (use back of paper if needed)

Blank lines for medication entry

All Others (including Over-the-Counter)

Medications

Blank lines for medication entry

SURGERIES (Please list below)

DATE (month/year)

Blank lines for surgery and date entry

FAMILY HISTORY

Relation

Current State of Health & History of Problems

Mother _____

Father _____

Siblings _____

Blank lines for family history entry