

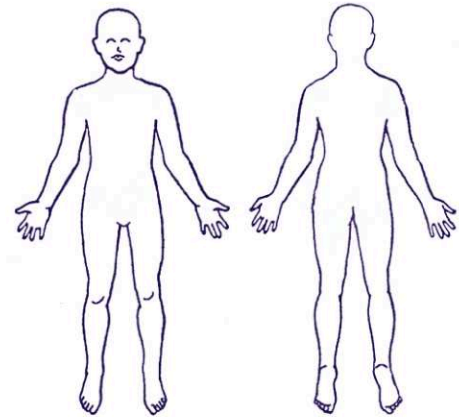
PATIENT NAME _____ DATE OF BIRTH _____
 REFERRING PHYSICIAN _____ PHONE _____
 PRIMARY CARE PHYSICIAN _____ PHONE _____
 YOUR PHARMACY _____ PHONE _____
 YOUR INSURANCE _____ PHONE _____

SECTION 1: HISTORY OF PRESENT ILLNESS

ARE YOU INVOLVED IN ANY COURT CASES OR LAWSUITS? YES NO
 IF YOURS IS A WORKER'S COMPENSATION CLAIM, IS YOUR CASE IN DISPUTE? YES NO
 AS BEST AS YOU UNDERSTAND, WHY DID YOUR REFERRING PHYSICIAN SEND YOU TO OUR CLINIC?

WHERE DO YOU HURT? MARK ALL THAT APPLY.

- | | | |
|--|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> LOW BACK | <input type="checkbox"/> MID-BACK | <input type="checkbox"/> KNEE |
| <input type="checkbox"/> NECK | <input type="checkbox"/> BUTTOCKS | <input type="checkbox"/> LEG |
| <input type="checkbox"/> HAND/FINGERS | <input type="checkbox"/> ABDOMEN | <input type="checkbox"/> HIP |
| <input type="checkbox"/> WRIST | <input type="checkbox"/> FOOT | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> CHEST WALL | <input type="checkbox"/> SHOULDER | <input type="checkbox"/> PELVIC PAIN |
| <input type="checkbox"/> OTHER _____ | | |
| <input type="checkbox"/> OTHER _____ | | |
| <input type="checkbox"/> I HURT EVERYWHERE | | |



DESCRIBE YOUR PAIN. MARK ALL THAT APPLY.

- | | | | | | |
|------------------------------------|-----------------------------------|-------------------------------------|------------------------------------|------------------------------------|---|
| <input type="checkbox"/> DULL | <input type="checkbox"/> ACHY | <input type="checkbox"/> DEPRESSING | <input type="checkbox"/> SHARP | <input type="checkbox"/> CRUEL | <input type="checkbox"/> THROBBING |
| <input type="checkbox"/> STABBING | <input type="checkbox"/> SHOOTING | <input type="checkbox"/> TINGLING | <input type="checkbox"/> NUMB | <input type="checkbox"/> BURNING | <input type="checkbox"/> PINS/NEEDLES |
| <input type="checkbox"/> SPLITTING | <input type="checkbox"/> PRESSURE | <input type="checkbox"/> RIPPING | <input type="checkbox"/> PUNISHING | <input type="checkbox"/> STRESSFUL | <input type="checkbox"/> UNBEARABLE |
| <input type="checkbox"/> FEARFUL | <input type="checkbox"/> CRUSHING | <input type="checkbox"/> SAD | <input type="checkbox"/> TEARFUL | <input type="checkbox"/> SQUEEZING | <input type="checkbox"/> UNCONTROLLABLE |

MARK YOUR PAIN SCORE. FROM 0 BEING NO PAIN, TO 10 BEING THE WORST.

0	1	2	3	4	5	6	7	8	9	10
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WHAT TIME OF DAY IS YOUR PAIN WORST? MORNING AFTERNOON EVENING NIGHT

WHEN DID YOUR PAIN START? _____

WAS THERE AN EVENT THAT STARTED YOUR PAIN? YES NO

IF YES, PLEASE DESCRIBE THE EVENT _____

HOW LONG DOES A PAIN FLARE LAST? SECONDS MINUTES HOURS DAYS

HOW OFTEN DOES YOUR PAIN FLARE?

- DAILY SEVERAL PER DAY ONCE OR TWICE WEEKLY RARELY

MARK YOUR INTERFERENCE SCORE FOR DAILY ACTIVITIES.

SCORES RANGE FROM 0 BEING NONE, TO 10 BEING COMPLETE INTERFERENCE

0 1 2 3 4 5 6 7 8 9 10

LIST THE ACTIVITIES THAT WORSEN THE PAIN _____

LIST THE ACTIVITIES THAT IMPROVE THE PAIN _____

SECTION 2: SLEEP

HOW MANY TOTAL HOURS OF SLEEP TIME EACH NIGHT? _____

HOW MANY TIMES DO YOU AWAKEN DUE TO PAIN? _____

HOW MANY TIMES DO YOU AWAKEN FOR BATHROOM TRIPS? _____

SECTION 3: MOOD

DURING THE PAST MONTH, HAVE YOU FELT DOWN, BLUE, DEPRESSED OR HOPELESS DUE TO PAIN? YES NO

HAVE YOU EVER FELT LIKE HARMING YOURSELF? YES NO

HAVE YOU EVER FELT LIKE HARMING ANYONE ELSE? YES NO

HAVE YOU EVER HAD A SUICIDE ATTEMPT? YES NO

DO YOU EVER HAVE PANIC ATTACKS? YES NO

HOW OFTEN? SEVERAL/DAY ONCE/DAY 2-3 TIMES/WEEK WEEKLY MONTHLY

RATE YOUR AVERAGE LEVEL OF ANXIETY/STRESS THAT YOU EXPERIENCE EVERY DAY.

SCORES RANGE FROM 0 BEING NO STRESS, TO 10 BEING VERY STRESSED.

0 1 2 3 4 5 6 7 8 9 10

SECTION 4: FUNCTION

MARK REGULAR ACTIVITIES YOU CANNOT DO BECAUSE OF PAIN. MARK ALL THAT APPLY.

- DRESSING SEX BATHING WALKING DISHWASHING DRIVING
 TOILET EXERCISING SWEEPING TRAVEL LAUNDRY COOKING MEALS
 BENDING CHILD CARE SITTING STANDING VACUUMING GROCERY SHOPPING
 EATING LIFTING EATING TYPING MOWING LAWN GARDENING

OTHER _____ OTHER _____

ARE YOU WORKING? YES NO HOW MANY HOURS/WEEK? _____

WHAT IS YOUR OCCUPATION? _____

HOW MANY DAYS/MONTH DO YOU TAKE OFF FROM WORK BECAUSE OF PAIN? _____

HAVE YOU HAD PROBLEMS WITH BOWEL OR BLADDER CONTROL? YES NO

SECTION 5: ALLERGIES

HAVE YOU EVER BEEN TOLD YOU HAVE A SEVERE ALLERGY TO A MEDICINE? YES NO

MEDICATIONS

REACTION

SECTION 6: MEDICATIONS PLEASE LIST ALL CURRENT MEDICATIONS AND DOSES.

MEDICATIONS

MEDICATIONS

DO YOU TAKE ANY BLOOD THINNERS LIKE **COUMADIN, PLAVIX, OR LOVENOX**? YES NO

DO YOU TAKE ANY OVER-THE-COUNTER MEDICINES CONTAINING TYLENOL OR ACETAMINOPHEN? YES NO

SECTION 7: OTHER MEDICAL PROBLEMS

LIST OTHER MEDICAL PROBLEMS (eg. HIGH BLOOD PRESSURE, DIABETES, ASTHMA, ETC.)

SECTION 8: OTHER SURGICAL PROBLEMS

LIST PAST SURGERIES AND THE DATES THEY WERE PERFORMED.

SURGERY	DATE	SURGERY	DATE
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>

PLEASE LIST ANY PREVIOUS PAIN INJECTIONS/PROCEDURES TRIED IN THE PAST.

INJECTION/PROCEDURE	DATE	INJECTION/PROCEDURE	DATE
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>

SECTION 9: FAMILY HISTORY

LIST ANY MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY.

SECTION 10: SOCIAL HISTORY

HAVE YOU EVER USED TOBACCO? YES NO

HOW MANY PACKS PER DAY? _____ FOR HOW MANY YEARS? _____

DO YOU DRINK ALCOHOL? YES NO HOW MANY DRINKS/WEEK? _____

HAVE YOU EVER USED STREET DRUGS? YES NO

CHECK THE ONES THAT YOU HAVE USED. MARIJUANA COCAINE METH HEROIN CRACK

HAVE YOU EVER FINISHED A PRESCRIPTION MEDICATION EARLIER THAN WAS PRESCRIBED OR RECEIVED

THE SAME MEDICATION FROM MULTIPLE PHYSICIANS? YES NO

MARITAL STATUS: MARRIED (# OF YEARS _____) DIVORCED (# OF YEARS _____) SINGLE WIDOWER

CHILDREN? YES NO (# OF CHILDREN: _____ AGES: _____)

SECTION 11: GENERAL HEALTH QUESTIONNAIRE

PLEASE CHECK ANY OF THE FOLLOWING PERSISTENT OR UNUSUAL HEALTH CONCERNS:

GENERAL ----- FEVER CHILLS NIGHT SWEATS EXCESSIVE FATIGUE WEIGHT LOSS WEAKNESS

EYES ----- CHANGE IN YOUR VISION EYE PAIN EYE SWELLING TEARING

EARS ----- HEARING LOSS RINGING IN THE EARS EAR PAIN DISCHARGE

NOSE ----- NOSE BLEEDS DISCHARGE STUFFY NOSE SINUS PROBLEMS LOSS OF SMELL

THROAT ----- SORE THROAT CHANGE IN TASTE DISCHARGE BAD BREATH DENTAL CAVITIES

NECK ----- STIFF NECK NECK PAIN WHIPLASH INJURY

HEART ----- HIGH BLOOD PRESSURE CHEST PAIN FAST OR SLOW HEARTBEAT SWOLLEN ANKLES
 FAINTING EXERCISE INTOLERATION

LUNGS ----- COUGH WHEEZING EMPHYSEMA BRONCHITIS SHORT OF BREATH
 COUGHING UP BLOOD

GASTROINTESTINAL - DIARRHEA CONSTIPATION ABDOMINAL PAIN HEARTBURN JAUNDICE
 HEPATITIS BLOOD IN STOOLS BLACK TARRY STOOLS HERNIA

URINARY ----- BURNING FREQUENCY URGENCY INCONTINENCE LOSS OF URINE/LEAKAGE
 KIDNEY STONES

MUSCULO SKELETAL --- STIFF JOINTS ARTHRITIS RESTLESS LEGS AT NIGHT
 MUSCLE SPASM SCOLIOSIS

SKIN ----- RASH ECZEMA DRY SKIN ITCHING

NEUROLOGICAL - NUMBNESS TINGLING WEAKNESS TRIPPING FALLING HEADACHES

PSYCHIATRIC - CLAUSTROPHOBIA PARANOIA NIGHTMARES HEARING VOICES

BLOOD ----- BLEED EASILY BRUISE EASILY FREQUENT BLOODY NOSE USING A BLOOD THINNER

OTHER -----

THIS FORM HAS BEEN COMPLETED TO THE BEST OF MY KNOWLEDGE

SIGNATURE

DATE

ADDRESS

PHONE

CITY STATE ZIP