

Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_

Who is your primary care physician/family doctor?

\_\_\_\_\_

What is the major reason you are coming to see the doctor (chief complaint):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Office Use Only

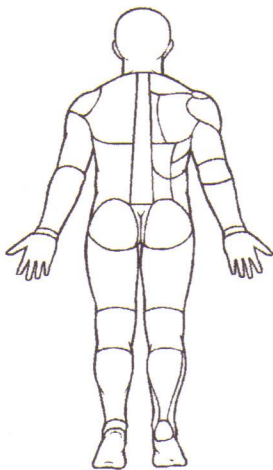
Blood Pressure: \_\_\_\_\_

Heart Rate: \_\_\_\_\_

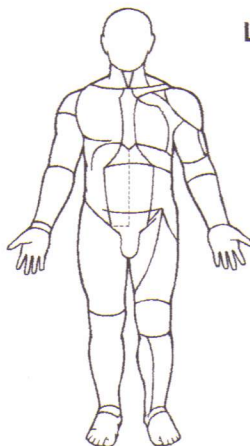
Temperature: \_\_\_\_\_

Weight: \_\_\_\_\_

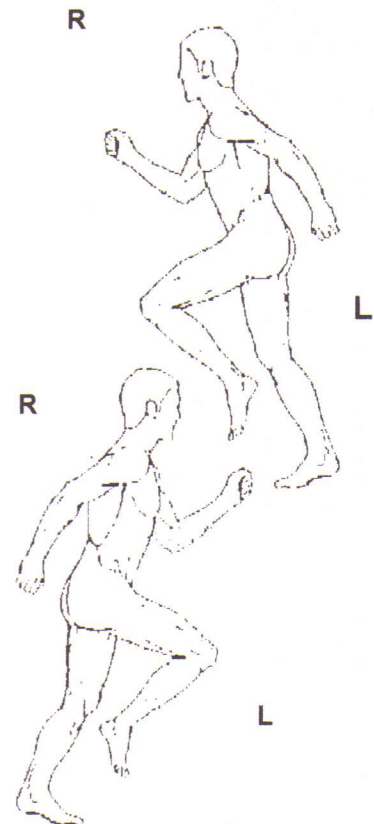
Mark an "X" on the figures below where your pain starts and show where it goes with an arrow.



R



L

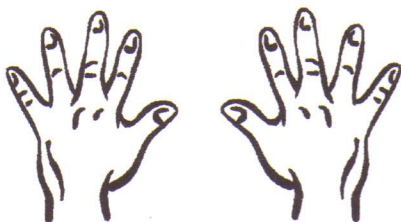
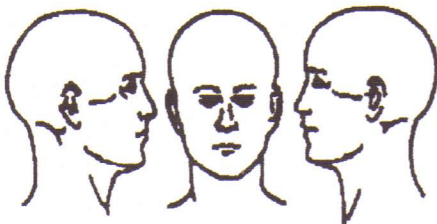


R

L

R

L



1/0

How long have you had this pain? \_\_\_\_\_  
When did it start? \_\_\_\_\_  
What were you doing when the pain first started? \_\_\_\_\_

How long does the pain last?

- Constant  
 Intermittent

**QUALITY OF YOUR PAIN:**

Please mark all that apply:

- Throbbing       Cramping       Gnawing       Aching       Shooting  
 Stabbing       Sharp       Hot-burning       Heavy       Tender  
 Splitting       Sickening       Tiring-Exhausting       Fearful  
 Punishing-Cruel       Other \_\_\_\_\_

**Intensity of Pain**

On a scale of 0-10, with 10 being the worst imaginable pain and 0 the absence of pain, how would you rate your pain?

At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
Average:	0	1	2	3	4	5	6	7	8	9	10

**What makes your pain worse?** Mark all that apply.

- Bending       Lifting       Coughing       Sneezing  
 Defecation       Prolonged Sitting       Walking       Prolonged Standing  
 Other, please explain \_\_\_\_\_

**What makes your pain better?** Mark all that apply.

- Rest       Activity/physical therapy       Massage       Heat  
 Cold       Lying in a fetal position       Lying on your back  
 Lying on back w/ pillows under your legs       Medication, please list \_\_\_\_\_  
 Other, please explain \_\_\_\_\_

**Are there other symptoms/problems associated with the pain?**

- Difficulty sleeping       Feel "blue" all the time  
 Other(s), please describe \_\_\_\_\_

**In what time period is your pain worst?**

- early morning       late evening

## TREATMENT HISTORY

How many times have you visited a professional caregiver (of any kind) for this *current* pain?

- 0-5     
  6-10     
  Can't Remember     
  Too many to count

Which of the following types of caregivers have you visited prior to your arrival here?

- Family Physician (includes general practitioner, internist, gynecologist, etc.)  
 Sports Medicine       Orthopedic/Spine Surgeon       Neurologist  
 Rheumatologist       Occupational Medicine       Anesthesiologist  
 Rehabilitation Medicine       Pain Management       Chiropractor  
 Osteopathic Physician       Acupuncturist       Biofeedback  
 Alternative medicine       Physical Therapist  
 Other, please list \_\_\_\_\_

Which of the following tests have you undergone prior to your arrival here today?

- X-rays       CAT scan       MRI scan       EMG test  
 Discogram/Discography       Myelogram

Please check the medications that you have tried for your pain in the past and their effectiveness. (0=no help, 10=very helpful)

Name of medication	Tried Medication		Effectiveness (0-10)
	Yes	No	
Tylenol/acetaminophen			
NSAID's: Motrin/Advil/Ibuprofen, etc			
Opioids: Vicodin/Norco/Oxycodone, etc			
Oral Steroids/Medrol dose pack			
Amitriptyline(Elavil), Nortriptyline(Pamelor), etc			
Muscle relaxants/Flexaril			
Neurontin/Topamax/Tegretol, etc			
Marijuana/Cocaine/Heroin/Other illicit drugs			
Xanax/Ativan/Valium,etc			
Others, please list			

Have you had any of the following interventions done for your pain?

- TENS/nerve stimulator       ultrasound       Heat       Cold

- Nerve block injections (not steroids)

If so, how many times?       1       2       3       4 or more

- Trigger point injections

If so, how many times?       1       2       3       4 or more

- Other, please list \_\_\_\_\_

## PAST MEDICAL HISTORY

Drug and Food Allergies:

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Please list the medications you are currently taking:

Name	Dosage	How Often?

List all **MEDICAL** problems:

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List all **SURGERIES** and their dates:

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## SOCIAL HISTORY

Any use of tobacco (type and for how long?)

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Any use of alcohol (type and for how long?)

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Any use of recreational drugs (type and for how long?)

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Any exposure to toxins/poisonous substances at work or with hobbies?

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What type of work do you do?

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Are you currently on disability:                      ( ) Yes                                      ( ) No

### Education:

Grade School    High School    College    Post-Graduate    Vocational Training

### Marital Status:

Single                      Married                      Divorced                      Separated                      Widowed

## FAMILY HISTORY

Mother:     Living     Deceased    Age(s) \_\_\_\_\_ Health issues: \_\_\_\_\_

Father:     Living     Deceased    Age(s) \_\_\_\_\_ Health issues: \_\_\_\_\_

Brother(s):  
# \_\_\_\_\_  Living     Deceased    Age(s) \_\_\_\_\_ Health issues: \_\_\_\_\_

Sister(s):  
# \_\_\_\_\_  Living     Deceased    Age(s) \_\_\_\_\_ Health issues: \_\_\_\_\_

