

Name \_\_\_\_\_ Date \_\_\_\_\_ Date of birth \_\_\_\_\_

Age \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Height: \_\_\_ ft. \_\_\_ in. Weight \_\_\_\_\_ lbs

Referring Physician \_\_\_\_\_ Primary Physician (Full Name) \_\_\_\_\_

List all other physicians involved in your care and their specialty. \_\_\_\_\_

**Have you had any of the following?**

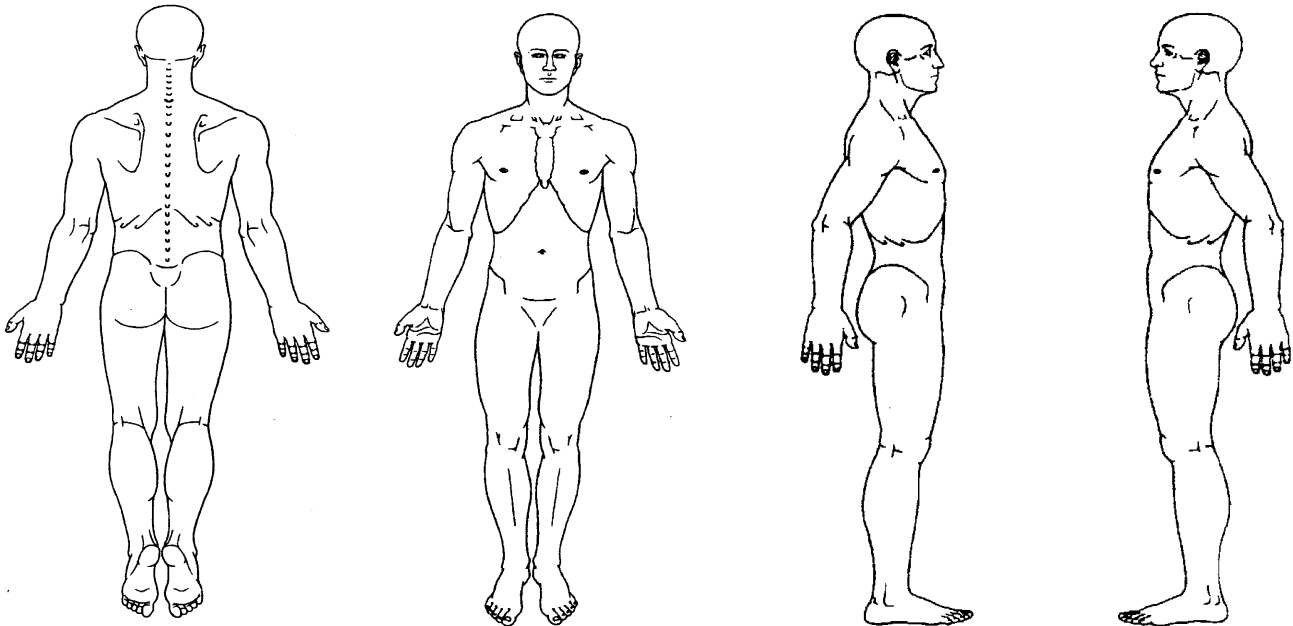
**MRI** Yes \_\_\_ No \_\_\_ Date \_\_\_\_\_ Where \_\_\_\_\_

**EMG** Yes \_\_\_ No \_\_\_ Date \_\_\_\_\_ Where \_\_\_\_\_

**CT SCAN** Yes \_\_\_ No \_\_\_ Date \_\_\_\_\_ Where \_\_\_\_\_

**Myelogram** Yes \_\_\_ No \_\_\_ Date \_\_\_\_\_ Where \_\_\_\_\_

Please **draw** where your pain **primarily located** (Please use following diagram.)



Was the injury work-related? Yes \_\_\_ No \_\_\_ Are you involved in a lawsuit? Yes \_\_\_ No \_\_\_

When did the pain begin? (Approximate date i.e.7/2009) \_\_\_\_\_

Did it begin gradually or suddenly?  Gradually  Suddenly

If suddenly, is it the result of an injury?  Yes  No

If so, please describe the injury. \_\_\_\_\_

Is it getting worse or has it improved?  Improving  Worsening

Please describe your pain in as much detail as possible. \_\_\_\_\_

Please mark your average (A) pain and your maximum (M) pain on the line below:

0 1 2 3 4 5 6 7 8 9 10  
 No Pain \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ Worst Pain Imaginable

Please rate your pain as of right now from 0-10: \_\_\_\_\_

Do you have any other symptoms such as numbness, weakness, or pins and needles sensations? Please describe.

\_\_\_\_\_

➤ Do you have new onset of bowel or bladder problems related to this?  YES  No

What makes your pain worse? Standing \_\_\_\_\_ Sitting \_\_\_\_\_ Walking \_\_\_\_\_ Lying Down \_\_\_\_\_

Does the pain affect your sleeping? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, how? \_\_\_\_\_

\_\_\_\_\_

What have you found that makes your pain better? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Does the pain interfere with your ability to work? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, how? \_\_\_\_\_

Please circle any of the following activities of daily living that you have had difficulty doing because of your pain:

Using the toilet      Dressing      Bathing      Eating      Getting up from a bed or chair

If you have experienced **NO** difficulty with the above activities of daily living please check this box:

Do you need any assistance walking? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, what type? \_\_\_\_\_

Please list any previous treatments for your pain:

Treatment	Please Circle Yes or No	Dates of Treatment (i.e. 7/2009- 10/2009)	Did the treatment relieve your pain?
Physical Therapy	Yes/No		Yes/No
Chiropractor	Yes/No		Yes/No
Injections/Blocks	Yes/No		Yes/No
Home Exercise	Yes/No		Yes/No
TENS/Electrical Stimulation	Yes/No		Yes/No
Traction	Yes/No		Yes/No
Bed Rest/Rest	Yes/No		Yes/No
Back Support	Yes/No		Yes/No

If you have tried any medications for pain relief please list them below and include the length of time they were tried (i.e. 2 months): (including Tylenol, Advil, and/or Prescription Drugs):

_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies to any medications, latex, iodine, contrast dye, or tape? Yes\_\_ No \_\_

**Allergies to Medications and Reactions:**

Item/Drug	Reaction	Item/Drug	Reaction

ARE YOU TAKING ANY BLOOD-THINNING MEDICATIONS? (i.e. ASPIRIN, COUMADIN, TICLID, PLAVIX)

YES \_\_\_\_\_ NO \_\_\_\_\_

Please list ALL medications you are currently taking. Include vitamins, over-the-counter medications, herbal preparations, laxatives, or inhalers.

Medication & Dose	How often	Medication & Dose	How often
1)		7)	
2)		8)	
3)		9)	
4)		10)	
5)		11)	
6)		12)	

Do you currently have or are you being treated for an infection of any kind? If yes, please explain:

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**Review of Systems:**

Do you have or have you had any of the following conditions?

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Fever, chills, night sweats | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Nausea, vomiting                | <input type="checkbox"/> Tremor, seizures, or blackouts |
| <input type="checkbox"/> Weight gain or loss         | <input type="checkbox"/> Palpitations           | <input type="checkbox"/> Poor appetite                   | <input type="checkbox"/> Depression or anxiety          |
| <input type="checkbox"/> Fatigue, lack of energy     | <input type="checkbox"/> Irregular heartbeat    | <input type="checkbox"/> Diarrhea                        | <input type="checkbox"/> Heat or cold intolerance       |
| <input type="checkbox"/> Glaucoma, cataracts         | <input type="checkbox"/> Swelling ankles, hands | <input type="checkbox"/> Constipation                    | <input type="checkbox"/> Unusual bleeding or bruising   |
| <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Pain with urination             | <input type="checkbox"/> Glasses                        |
| <input type="checkbox"/> Deafness, ringing in ears   | <input type="checkbox"/> Wheezing or cough      | <input type="checkbox"/> Skin rash or itching            |   |
| <input type="checkbox"/> Sinus problems              | <input type="checkbox"/> Heartburn              | <input type="checkbox"/> Joint pain, swelling, stiffness |   |
| <input type="checkbox"/> Nosebleeds                  | <input type="checkbox"/> Pain in stomach        | <input type="checkbox"/> Hard of hearing                 |   |

All others Negative

Comments: (Explain anything marked above, if necessary.) \_\_\_\_\_

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**Please mark any health problem you have had in the past**

- |  |   |   |   |                                    |
|--|---|---|---|------------------------------------|
| <input type="checkbox"/> Heart Disease                         | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Heart Failure      | <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> Asthma    |
| <input type="checkbox"/> High Blood Pressure                   | <input type="checkbox"/> Stroke/TIA               | <input type="checkbox"/> Hypo/Hyper Thyroid | <input type="checkbox"/> Gastritis            | <input type="checkbox"/> Ulcers    |
| <input type="checkbox"/> Infectious Conditions, i.e. Hepatitis |   | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Neuropathy           | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Cancer, Type _____                    |   | <input type="checkbox"/> Mental Disorder    | <input type="checkbox"/> Depression           | <input type="checkbox"/> Glaucoma  |
| <input type="checkbox"/> Kidney Disease                        | <input type="checkbox"/> Kidney Infections        | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Circulation Problems |                                    |

**Please list any surgeries you have had**

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Surgery: \_\_\_\_\_

Is there any possibility you could be pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

**Health History:**

	Age (Living)	Age (At Death)	State of Health/Illnesses/Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings:			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Tobacco Use:** Packs/Day \_\_\_\_\_ Number of Years \_\_\_\_\_ Packs/Day \_\_\_\_\_ Number of Years \_\_\_\_\_  
 (Currently) (Previously)

If you have quit smoking, how long ago? \_\_\_\_\_

Alcohol Use \_\_\_\_\_ Amount per Week

Form completed by:

\_\_\_\_\_  
 \_\_\_\_\_ M.D. \_\_\_\_\_ Date  
 \_\_\_\_\_ R.N. \_\_\_\_\_ Date

**Name of who will drive you home today**

\_\_\_\_\_  
 Form reviewed: \_\_\_\_\_ M.D. \_\_\_\_\_ Date  
 \_\_\_\_\_ R.N. \_\_\_\_\_ Date