



Who is your primary care physician/family doctor? \_\_\_\_\_

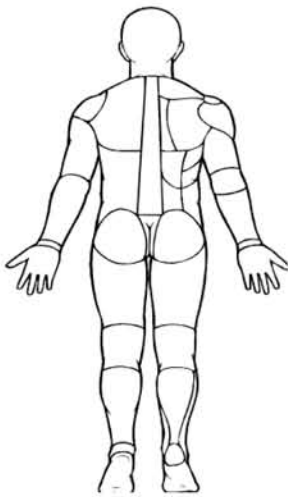
What is the major reason you are coming to see the doctor (chief complaint):

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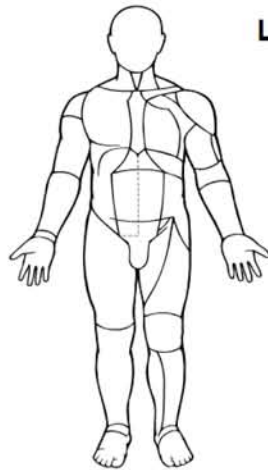
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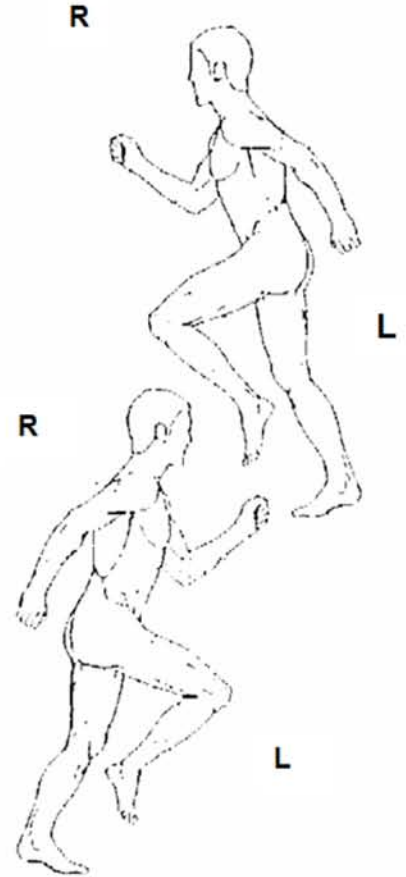
Mark an "X" on the figure below where your pain starts and show where it goes with an arrow.



R



L

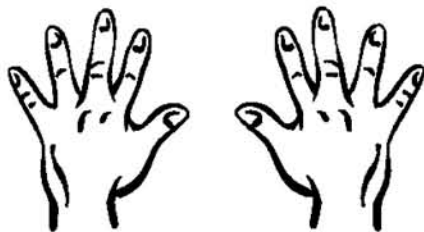
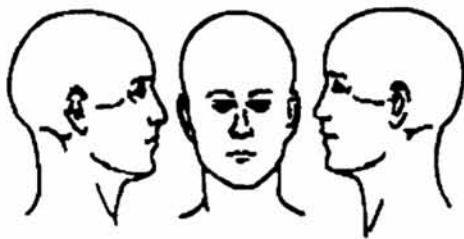


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How long have you had this pain? \_\_\_\_\_

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.**

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 / Herion / 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: \_\_\_\_\_

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: \_\_\_\_\_



## REVIEW OF SYSTEMS

Please place a checkmark if you currently have any of the following symptoms. (Disregard the bold headings)

• **Constitutional**

No Problems       Fever       Weight Loss       Fatigue

• **Eyes**

No Problems       Blurred Vision       Eye Redness       Double Vision  
 Vision Loss       Eye Dryness       Eye Pain

• **Ear/Nose/Throat**

No Problems       Trouble Hearing       Ringing in the ear       Loss of Balance  
 Dizziness/Vertigo       Ear Discharge       Ear Pain

• **Cardiovascular**

No Problems       Chest Pain/Angina       Irregular Heart Beat       Fainting  
 Limb Swelling       Limb Pain on Walking

• **Respiratory**

No Problems       Trouble Breathing       Chronic Cough       Coughing Blood

• **Gastrointestinal**

No Problems       Indigestion       Nausea       Vomiting       Diarrhea  
 Heart Burn       Constipation       Bloody Stools       Abdominal Pain

• **Genitourinary**

No Problems       Incontinence       Pain on Urination       Blood in Urine

• **Musculoskeletal**

No Problems       Muscle Pain       Muscle Cramp       Neck Pain       Back Pain  
 Joint Swelling       Joint Pain       Joint Stiffness       Muscle Twitches

• **Skin & Breast**

No Problems       Numbness       Hair Loss       Discoloration       Tingling  
 Sweating Change       Nail Change

• **Neurologic**

No Problems       Headache       Weakness       Tremors       Seizures  
 Trouble with Memory/Concentration       Blackouts       Face Numbness/Pain

• **Psychiatric**

No Problems       Hallucinations       Feeling Down       Trouble Sleeping  
 Suicidal Thoughts       Inappropriate Crying/Laughing

• **Hematologic/Lymphatic**

No Problems       Abnormal Bleeding       Anemia       Lumps/Swellings

• **Allergic/Immunologic**

No Problems       Rash       Joint Pain       Dry Eyes +/- Mouth

• **Endocrinologic**

No Problems       Excessive Thirst       Excessive Urination       Heat/Cold Intolerance

Person completing this questionnaire \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

For office use: This questionnaire may be completed by the patient, relatives or ancillary staff provided that it is signed and dated by the treating physician. (Reference may later be made to this information by a signed and dated statement by the treating physician, designating location of the information, date obtained and any subsequent changes.)

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_