COMPREHENSIVE PAIN SPECIALISTS

**NAME:** _____ **DOB / AGE:** _____ **DATE:** _____

**REFERRING DOCTOR:** _____

ARE YOU: ☐ MALE ☐ FEMALE
☐ RIGHT HANDED ☐ LEFT HANDED ☐ AMBIDEXTROUS

## WORK HISTORY:

OCCUPATION: _____ EMPLOYER: _____ HOW LONG IN POSITION? _____

PLEASE DESCRIBE YOUR JOB DUTIES: _____

_____

ARE YOU WORKING? ☐ NO DATE LAST WORKED: _____
☐ YES ☐ FULL TIME ☐ PART TIME

RESTRICTIONS: ☐ NO ☐ YES

IF YES, PLEASE DESCRIBE: _____

_____

_____

## CHIEF COMPLAINT:

REASON FOR VISIT: _____

LOCATION OF YOUR PAIN:

| | | | |
|---|---|---|---|
| ☐ HEAD | ☐ SHOULDER | ☐ MID BACK | ☐ LEG |
| ☐ NECK | ☐ ARM | ☐ LOW BACK | ☐ KNEE |
| ☐ HEADACHES | ☐ WRIST/HAND | ☐ HIPS/BUTTOCKS | ☐ ANKLE/FOOT |

## HISTORY OF PRESENT ILLNESS:

DATE OF INJURY OR SYMPTOM ONSET: _____

TYPE OF INJURY: ☐ SPORTS INJURY ☐ JOB ACCIDENT ☐ CAR ACCIDENT

☐ OTHER (EXPLAIN): _____

**PLEASE DESCRIBE IN DETAIL HOW YOU WERE INJURED:** _____

_____

_____

_____

**0 NO PAIN - 10 WORST PAIN IMAGINABLE**

CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PAIN AT ITS WORST DURING THE LAST MONTH. **0 1 2 3 4 5 6 7 8 9 10**
CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PAIN AT ITS LEAST DURING THE LAST MONTH. **0 1 2 3 4 5 6 7 8 9 10**
CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PAIN ON AVERAGE DURING THE LAST MONTH. **0 1 2 3 4 5 6 7 8 9 10**
CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PAIN AS IT IS RIGHT NOW. **0 1 2 3 4 5 6 7 8 9 10**

PLEASE DESCRIBE YOUR **CURRENT SYMPTOMS:** _____

_____

_____

WHAT MAKES YOUR PAIN WORSE? _____

WHAT MAKES YOUR PAIN BETTER? _____

SINCE ONSET, IS YOUR PAIN: ☐ BETTER ☐ SAME ☐ WORSE

IF YOUR PAIN HAS CHANGED, BY WHAT PERCENTAGE: **10 20 30 40 50 60 70 80 90 100%**

## PREVIOUS TREATMENT:

HAVE YOU HAD TREATMENT SINCE YOUR INJURY? ☐ NO ☐ YES

| | | | | | | |
|---|---|---|---|---|---|---|
| ER VISIT | ☐ NO | ☐ YES | WHERE? _____ | DATE _____ | | |
| X-RAYS | ☐ NO | ☐ YES | WHERE? _____ | BODY PART _____ | DATE _____ | |
| CT SCAN | ☐ NO | ☐ YES | WHERE? _____ | BODY PART _____ | DATE _____ | |
| MRI | ☐ NO | ☐ YES | WHERE? _____ | BODY PART _____ | DATE _____ | |
| EMG | ☐ NO | ☐ YES | | | | |
| EPIDURAL | ☐ NO | ☐ YES | | | | |

OTHER (PLEASE EXPLAIN) _____

## MEDICAL PROVIDER:

DR. _____ DATE OF 1ST VISIT _____ LAST VISIT _____

DIAGNOSIS GIVEN: _____

MEDICATIONS GIVEN: _____

OTHER TREATMENT PROVIDED: _____

DR. _____ DATE OF 1ST VISIT _____ LAST VISIT _____

DIAGNOSIS GIVEN: _____

MEDICATIONS GIVEN: _____

OTHER TREATMENT PROVIDED: _____

DR. _____ DATE OF 1ST VISIT _____ LAST VISIT _____

DIAGNOSIS GIVEN: _____

MEDICATIONS GIVEN: _____

OTHER TREATMENT PROVIDED: _____

**CHIROPRACTIC:** ☐ NO ☐ YES

DR. _____ DATE OF 1ST VISIT _____ LAST VISIT _____

FREQUENCY: ☐ EVERY DAY ☐ THREE TIMES/WEEK ☐ TWO TIMES/WEEK ☐ WEEKLY

HAS IT HELPED? ☐ NO ☐ YES

**PHYISCAL THERAPY:** ☐ NO ☐ YES ONGOING ☐ NO ☐ YES HOME EXERCISE PROGRAM ☐ NO ☐ YES HAS IT HELPED?

## FUNCTIONAL HISTORY:

HAS THIS CONDITION INTERFERED WITH YOUR:
SOCIAL LIFE ☐ NO ☐ YES

WORK ☐NO ☐YES

AT ANY ONE TIME HOW MANY HOURS CAN YOU: SIT: _____ STAND: _____ WALK: _____

IN AN 8 HOUR DAY, HOW MANY HOURS CAN YOU: SIT: _____ STAND: _____ WALK: _____

HOW MANY POUNDS CAN YOU LIFT AT ONE TIME? _____

HOW OFTEN? ☐ NEVER ☐ OCCASIONALLY ☐ FREQUENTLY ☐ CONTINUOUSLY

HOW FAR CAN YOU WALK? ☐ 0-2 BLOCKS ☐ 4-6 BLOCKS ☐ A MILE OR MORE

## CURRENT MEDICATIONS FROM DOCTORS AND DENTISTS:

1_____ MG ___ DOSAGE_____ 2_____ MG ____ DOSAGE_____

3_____ MG ___ DOSAGE_____ 4_____ MG ____ DOSAGE_____

5_____ MG ___ DOSAGE_____ 6_____ MG ____ DOSAGE_____

7_____ MG ___ DOSAGE_____ 8_____ MG ____ DOSAGE_____

**MEDICATION ALLERGIES:** ☐ NO ☐ YES

IF YES, PLEASE LIST:

1. _____ / REACTION: _____
2. _____ / REACTION: _____
3. _____ / REACTION: _____

## PAST MEDICAL HISTORY:

| | | |
|---|---|---|
| ☐ ANXIETY | ☐ HEART ATTACK/CAD | ☐ THYROID TROUBLE |
| ☐ DEPRESSION | ☐ HIGH BLOOD PRESSURE | ☐ MIGRAINES |
| ☐ LIVER DIS | ☐ ULCERS/PUD | ☐ HIGH CHOLESTEROL |
| ☐ CANCER | ☐ LUNG DISEASE | ☐ ALCOHOLISM |
| ☐ ARTHRITIS | ☐ STROKE | ☐ DIABETES |

HAVE YOU HAD SIMILAR SYMPTOMS/INJURY BEFORE? ☐ NO ☐ YES

IF YES, WHEN: _____ PLEASE DESCRIBE BRIEFLY: _____

_____

## PAST SURGICAL HISTORY:

HAVE YOU HAD ANY SURGERIES? ☐ NO ☐ YES

IF YES, PLEASE LIST TYPE OF SURGERY/DIAGNOSIS AND DATE:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

## SOCIAL HISTORY:

MARITAL STATUS: (CHECK ONE OR MORE)

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED

NUMBER OF CHILDREN: ____

DO YOU SMOKE? □ NO □ YES HOW MUCH? _____

PREVIOUS SMOKER? □ NO □ YES WHEN STOPPED? _____

DO YOU DRINK ALCOHOL? □ NO □ YES HOW MUCH? _____

DO YOU USE RECREATIONAL DRUGS? ☐ NO ☐ YES

IF YES, WHAT TYPE/HOW OFTEN? _____

**REVIEW OF SYSTEMS:** PLEASE CHECK IF YOU **CURRENTLY** EXPERIENCE ANY OF THE FOLLOWING.

**GENERAL**

☐ FEVER ☐ WEIGHT GAIN/LOSS ☐ FATIGUE ☐CHILLS ☐ WEAKNESS

**HEAD**

☐ TRAUMA ☐ HEADACHES ☐ TENDERNESS ☐ DIZZINESS

**HEARING**

☐ CHANGES (LOSS) ☐ RINGING IN EARS ☐ DISCHARGE

**VISION**

☐ CHANGES (LOSS) ☐ BLURRED VISION ☐ DISCHARGE ☐ GLASSES

☐ BLINDNESS ☐ RINGS AROUND LIGHTS ☐ DOUBLE VISION ☐ LIGHT SENSITIVITY

**GASTROINTESTINAL**

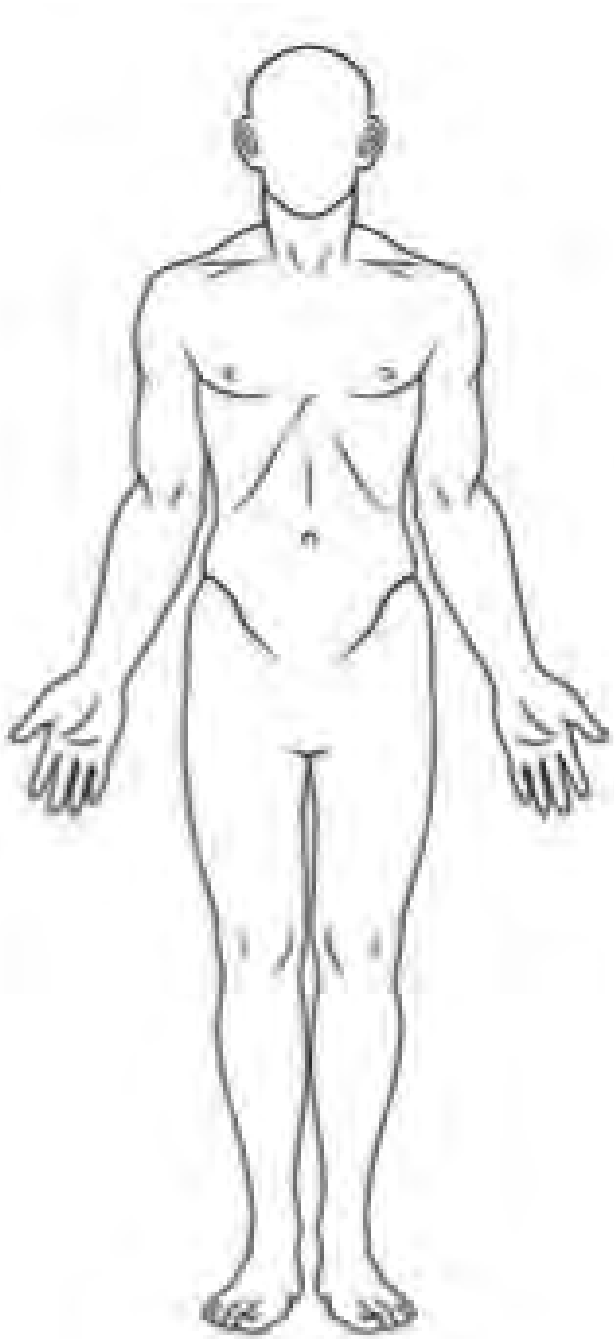
☐ DIFFICULTY CONTROLLING BOWELS ☐ HEARTBURN ☐ CONSTIPATION ☐ DIARRHEA

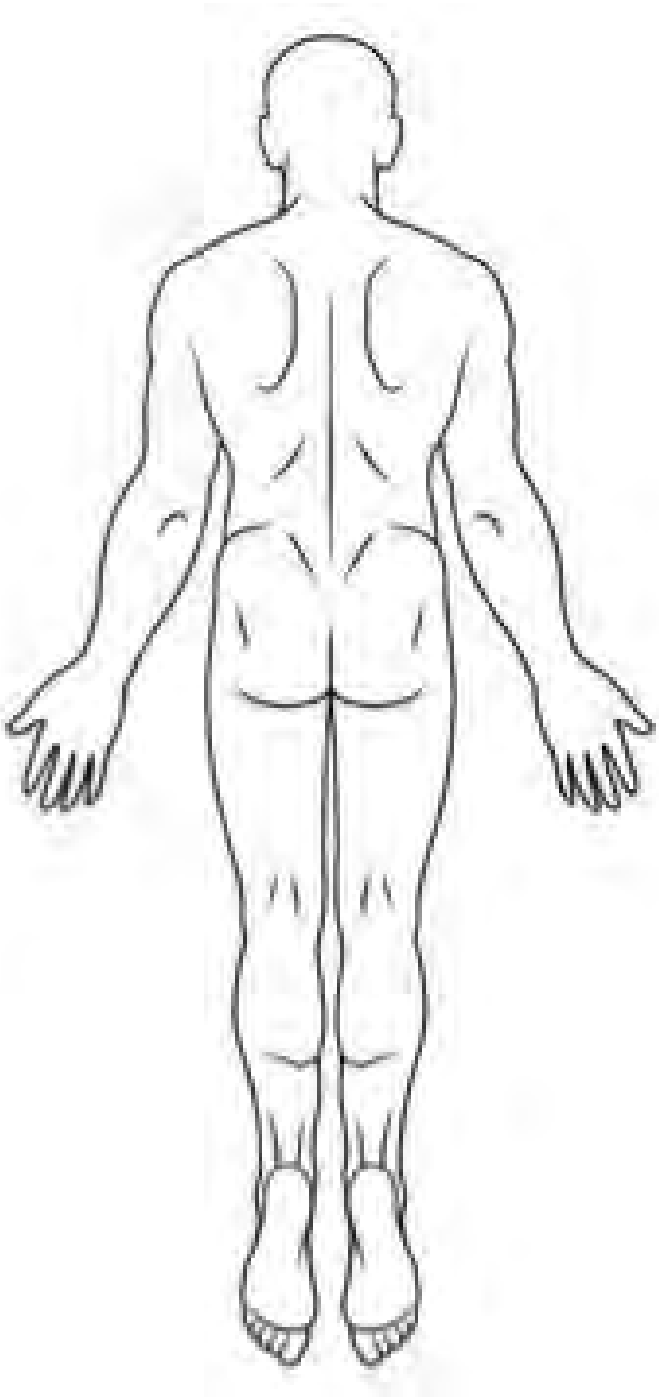
**GENITOURINARY**

☐ FREQUENCY OF URINATION ☐URGENCY WITH URINATION ☐URINATING AT NIGHT ☐INCONTINENCE ☐STERILITY/IMPOTENCE

**MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOL. MARK AREAS OF RADIATION. INCLUDE ALL AFFECTED AREAS.**

**NUMBNESS OOOO ACHE ^^^^^ STABING //// TINGLING ==== CRAMPING □□□□ BURNING XXXX**





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**FOR STAFF USE ONLY – PLEASE DO NOT COMPLETE**

**HEIGHT** _____ **WEIGHT** _____ **BLOOD PRESSURE** _____/_____ **GRIP STRENGTH: L.** _____

**R.** _____

**CIRCUMFERENCE: UPPER ARM: L.** _____ **FOREARM: L.** _____ **THIGH: L.** _____ **CALF: L.** _____

**R.** _____ **R.** _____ **R.** _____ **R.** _____