**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Greatest area of pain?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

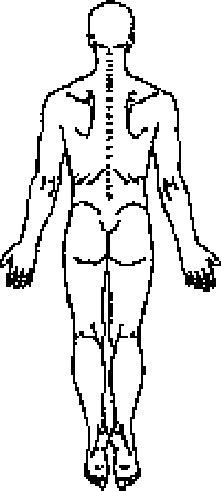
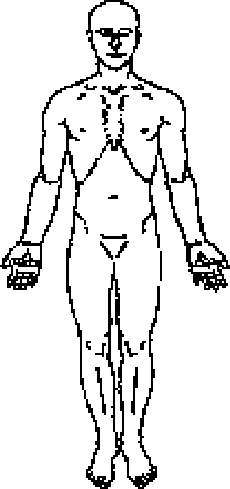
**When did it start?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

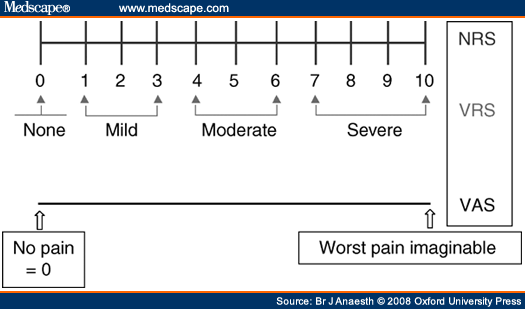
**Have you been to another pain clinic?**

\_\_\_\_No

\_\_\_\_Yes Physician(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please shade in your areas of pain in the diagrams below:**





Please rate your pain on a scale of 0 to 10:

For **TODAY:** \_\_\_\_\_\_\_\_\_\_\_

At its most **SEVERE**: \_\_\_\_\_\_\_

**How do you describe your pain?**

Aching  Numbness  Stinging  Superficial

Burning  Sharp  Throbbing  Deep

Dull  Shooting  Tightness

Electric-like  Stabbing  Cramping

**Which statement best describes your pain:**

It is constant  It occurs suddenly  It occurs in the morning

It is intermittent  It occurs gradually  It occurs in the daytime

It occurs occasionally  It occurs at evening

It occurs rarely  It wakes me from sleep

**Under what circumstances did your pain begin?**

Unknown  Lifting  Sports Injury  Surgical complication

Gradual onset  Overusing  Work Injury  Following surgery

Abrupt onset  During Exercise  Motor Vehicle Accident

After a fall  After Exercise  Assault

**What makes your pain better?**

Nothing helps  Standing  leaning forward  Prescription medication

Heat  Lying down  Stretching  Oral steroids

Ice  Walking  Physical therapy  Steroid injections

Rest  Position change  Chiropractic care  Anti-inflammatories/NSAID

Sitting  while being active  Over the counter medication  Narcotic medication

**What makes your pain worse?**

Nothing  Lifting  Exercise  Cold Weather

Sitting  Twisting  Flexion  Damp Weather

Standing  Movement  Extension

Walking  Pushing/Pulling  Getting out of bed

Lying down  Gripping  Going from sitting to standing

**Do you have any of these symptoms with your pain?**

weakness  Tingling  Redness  bruising

numbness  Swelling  Warmth  Bowel or bladder changes

**Have you had any of the following treatments for your pain?**

Physical Therapy  Did not help  Helped a little  Helped significantly  Helped temporarily

Chiropractic Therapy  Did not help  Helped a little  Helped significantly  Helped temporarily

Epidural Steroid Injection  Did not help  Helped a little  Helped significantly  Helped temporarily

Facet Injection  Did not help  Helped a little  Helped significantly  Helped temporarily

Facet Ablation  Did not help  Helped a little  Helped significantly  Helped temporarily

Sacroiliac Joint Injection  Did not help  Helped a little  Helped significantly  Helped temporarily

Steroid Injection  Did not help  Helped a little  Helped significantly  Helped temporarily

Synvisc/Euflexxa/Hyalgan  Did not help  Helped a little  Helped significantly  Helped temporarily

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Did not help  Helped a little  Helped significantly  Helped temporarily

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Did not help  Helped a little  Helped significantly  Helped temporarily

**Do you currently have any of the following symptoms?**

Constitutional: ☐ Fever ☐ Night sweats ☐ significant weight gain ☐ significant weight loss ☐ Chills

Eyes: ☐ Abrupt vision change ☐ Eye irritation ☐ Eye discharge

Ears/Nose/Mouth: ☐ Ear pain ☐ Frequent nosebleeds ☐ Sore throat ☐ Mouth ulcers

Cardiovascular: ☐ Chest pain ☐ Arm pain on exertion ☐ Shortness of breath when walking ☐ Heart murmur

☐ Ankle swelling

Respiratory: ☐ Cough ☐ Shortness of breath

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Dyspepsia (heartburn)

Genitourinary: ☐ Incontinence ☐ Difficulty urinating ☐ Increased frequency ☐ Blood in urine

Skin: ☐ Yellowing of skin ☐ Rashes ☐ Non healing areas ☐ Changes in hair/nails

Neurologic: ☐ Seizures ☐ Dizziness ☐ Tremor

Psychiatric: ☐ Depression ☐ Hallucinations ☐ Suicidal thoughts ☐ Memory loss

Endocrine: ☐ Fatigue☐ Increased thirst ☐ Abnormal hair loss

Hematologic/Lymphatic: ☐ Swollen glands ☐ Bruising ☐ Excessive bleeding

Allergy/Immunologic: ☐ Hives ☐ Itching ☐ Frequent colds/flu

**Please list any medical illnesses that you may have:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Please list any surgeries you have undergone:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Family History:**

Family Member Please list their major health problems

Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brothers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sisters \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal History:**

Marital Status: Married Single Divorced Widowed

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you receiving disability? Yes No Disability diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you live: Independently Require home assistance Assisted facility

Do you smoke? Yes No Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes No Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use illegal drugs? Yes No Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a history of:  Alcoholism  Drug Addiction

**Allergies to medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any medications you have tried for your pain:**

Medication Did it help? Side Effects?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list or attach a copy of all medications you are taking now:**

Medication Dose How many times a day

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

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

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