BOYNTON BEACH
Comprehensive Pain & Rehabilitation
CENTER

Adding Quality to Life.

Name: _____ **Date:** _____

Age: _____

Please answer all applicable questions that most describe your condition

What is your most significant problem? _____

When did it begin? ____/____/_____ **Is if constant?** ____ **or intermittent?** ____

To what do you contribute your pain or condition? _____

How do you rate your pain? (0= absence of pain, 10= worst pain imaginable) _____

Did it occur spontaneously? ___ YES ___ NO **Did occur due to an accident?** ___ YES ___NO

Does your pain radiate or shoot? _____ **If so, to where?** _____

Does any of the below actions worsen your pain?
□ **walking** □ **standing** □ **laying** □ **changing position** □ **coughing** □ **laughing**

What makes your pain or condition worse? _____

What makes your pain or condition better? _____

For your condition have you seen a physician? Y or N **Chiropractor?** Y or N **Therapist?** Y or N

What have they told you? _____ **What have they done?** _____

Name(s) of those seen: _____

Have you had any recent bladder or bowel changes? □ YES □ NO

Have you had any weakness of the arms or legs? □ YES □ NO

Please note the diagnostic test(s) you have had specific to your condition and write the results if you know them:

Nerve Conduction Study(NCS)/Electromyogram(EMG) results: _____

MRI/CT Scan results: _____

X-Ray results: _____

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NAME: _____ DATE: _____

Circle any treatments you have had for this pain or condition and write YES if it was helpful.

Acupuncture _____ Biofeedback _____ Nerve Block _____ Physical Therapy _____
Epidural Injections _____ Aerobic Exercise _____ Exercise Program _____
Tens Unit _____ Psychological Counseling _____ Occupational Therapy _____

Do you now or have you ever had any of the following? CIRCLE IF YES AND NOTE ANY DETAILS:

Angina _____
Arrhythmia _____
Asthma _____
Arthritis _____
Breast disease _____
Cancer _____
Coronary artery disease _____
Diverticulosis _____
Diabetes (insulin dependent _____
Or non insulin dependent _____
Headaches _____
Heart attack _____
Hypertension _____
Intestinal problems _____
Kidney disease _____
Mental health condition _____
Neuropathy _____
Osteoporosis _____
Pacemaker _____
Prostate condition _____
Renal disease _____
Seizure disorder _____
Stroke, TIA _____
Thyroid condition _____
Ulcers _____
Urological condition _____
Other _____
Other _____

When was your last colonoscopy/sigmoidoscopy? _____

FEMALE PATIENTS: Do you visit a gynecologist regularly? ☐ YES ☐ NO
When was your last mammogram? _____

MALE PATIENTS: Have you had a prostate screening (PSA) recently? ☐ YES ☐ NO

List all surgeries and dates: _____

_____

_____

List all medications you are presently taking and prescribing physician: _____

_____

_____

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NAME: _____ **DATE:** _____

Pain Medications: _____

_____

Drug allergies and reaction: _____

Social History

Do you smoke cigarettes? ◻ Yes ◻ No Number of cigarettes day ____?

Did you ever smoke? ◻ Yes ◻ No Do you drink alcohol? ◻ Yes ◻ No Number of drinks per day? ____

Do you have a history of alcohol abuse? ◻ Yes ◻ No Or drug abuse? ◻ Yes ◻ No

Do you have steps at home? ◻ Yes ____ how many; ◻ No. With whom do you live? _____

Family history including illnesses, and if applicable, cause of death.

Mother: _____ **Father:** _____

Sister(s): _____

Brother(s): _____

REVIEW OF SYSTEMS – CHECK ANY POSITIVE FINDINGS **◻ CHECK HERE IF NONE APPLY**

GENERAL
- ◻ Weight changes
- ◻ Weakness
- ◻ Fatigue
- ◻ Fever
- ◻ Difficulty sleeping
- ◻ Sore throat
- ◻ Night sweats
- ◻ Chills

HEAD
- ◻ Headache
- ◻ Vision problems
- ◻ Glaucoma
- ◻ Cataracts

Hearing
- ◻ Ear ache
- ◻ Dizziness
- ◻ Nasal problems

RESPIRATORY
- ◻ Cough/ Phlegm
- ◻ Pneumonia
- ◻ Short of breath
- ◻ Tuberculosis

CARDIAC
- ◻ Chest pain
- ◻ Palpitations
- ◻ Murmur

GASTRO
- ◻ Nausea/vomiting
- ◻ Indigestion
- ◻ Pain
- ◻ Diarrhea
- ◻ Bleeding
- ◻ Constipation

GU
- ◻ Urinary pain
- ◻ Stones
- ◻ Urinary tract infection
- ◻ Menstrual problem
- ◻ Menopausal symptoms
- ◻ Impotence

SKELETAL
- ◻ Stiffness
- ◻ Swelling
- ◻ Cramps
- ◻ Varicose veins

NEURO
- ◻ Fainting
- ◻ Paralysis
- ◻ Weakness
- ◻ Tremor
- ◻ Tingling
- ◻ Seizures
- ◻ Memory problem
- ◻ Numbness

ENDOCRINE
- ◻ Temp. intolerance
- ◻ Frequent urination
- ◻ Hunger
- ◻ Thirst

HEMATOLOGIC
- ◻ Anemia
- ◻ Bruising
- ◻ Transfusions
- ◻ Allergies
- ◻ Bleeding

PSYCH
- ◻ Anxiety
- ◻ Nervousness
- ◻ Tension
- ◻ Depression
- ◻ Mood swings

SKIN
- ◻ Rashes
- ◻ Lumps, breast or other
- ◻ Itching
- ◻ Hair changes
- ◻ Nail changes

OTHER
- ◻ _____
- ◻ _____
- ◻ _____
- ◻ _____

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