**PLEASE COMPLETE THE FORM IN ITS ENTIRETY**

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**History of Present Illness**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been discharged from an inpatient facility in the past 30 days? If yes**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Discharge:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What part of your body are you being seen for today?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How and when did this problem start? Any Injuries?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **If there is pain where is it (be specific)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How would you describe the pain?**

Sharp Stabbing Dull Throbbing Electrical Burning Crushing Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Does it radiate? If yes, where?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Numbness Tingling Weakness

Location(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Do your symptoms wake you up at night?**

Yes No

**Do your symptoms affect your activities of daily living?** Yes No N/A

**Explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Do your symptoms affect your ability to work?**

Yes No **Explain:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do your symptoms affect your ability to drive?**

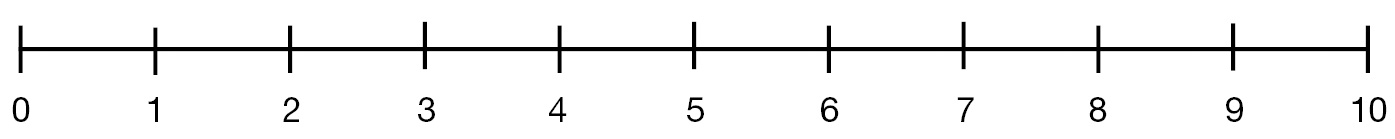
Yes No

**Is this work related?** YesNo

**Do you have a history of back pain or problems?**

Yes No

**On a scale 0-10 (0 = no pain; 10 = worst pain you can imagine) what is your level of pain?**

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**What treatments have you tried?**

Physical Therapy Ice Medication: \_\_\_\_\_\_\_\_\_\_\_\_ Injections (Steroid Gel) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe how you use stairs:**

Place one foot per step Use banister

Place both feet on step before proceeding to next Not applicable; don’t use stairs

**What makes your symptoms worse?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What makes your symptoms better?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How many street blocks can you walk?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Can you complete a trip to the grocery store?**

Yes No

**Can you put your own socks and shoes on?** Yes No

**Do you limp?**Yes No

**Do you use a walking device?** None Cane Crutches Walker Wheel Chair

How often and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the goal of your appointment today?**

Pain Management Better Function

Second opinion Surgery consult

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*PLEASE USE THE SPACE IN THE BACK TO EXPLAIN OR TELL THE DOCTOR ABOUT YOUR PROBLEM NOT COVERED IN THE FORM ABOVE\***