Name:_____ DOB: ____/____/_____ Today's Date: ____/____/_____

Brief History of Problem:_____

Approximate Onset of Problem: Number (#) of: _____ days, _____ weeks, and/or _____ years?

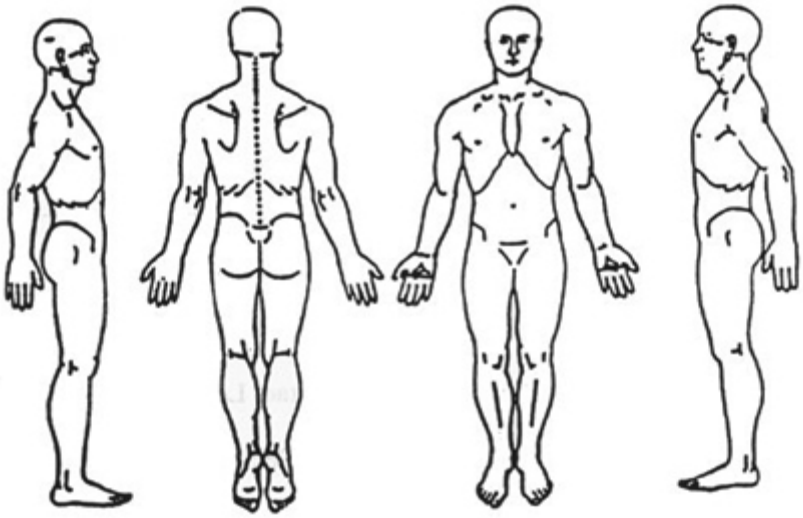
Did you have an injury? □ Yes □ No. If yes, did the injury occur at work? □ Yes □ No

(Please Note: We do not take Workman's Comp or accident injury)

Rate Severity of Pain from 0-10 (0=None, 10=Worst Possible): 0 1 2 3 4 5 6 7 8 9 10

Pain Diagram

Location of Pain: Mark or circle your location of pain



How often does your pain occur: □ Intermittent □ Continuously □ Activity Dependent □ At Rest

Relieves Pain: □ Rest □ Activity □ Other: _____

Increases Pain: □ Rest □ Activity □ Other: _____

How are you currently treating your pain? _____

Have you had pain management in the past? □ Yes □ No Do you have a letter of good standing? □ Yes □ No

Have you had tried any of these in the past for your current condition:

□ Injections What kind?_____

□ Pain Medications What kind?_____

□ Physical therapy For how long? _____

Review of Systems: [Check Any That Apply]

□ Weakness to _____	□ Fatigue	□ Headaches	□ Vision Changes	□ Poor Balance
□ Numbness to _____	□ Nausea	□ Vomiting	□ Chills/Fever	□ Persistent Cough
□ Tingling to _____	□ Depression	□ Dependence	□ Skin Problems	□ Insomnia
□ Skin Problems_____	□ Chest Pain	□ Shortness of Breath	□ Loss of bowel/bladder function	

Past Medical History: [Check Any That Apply]

□ Diabetes	□ Fibromyalgia	□ Stroke/TIA	□ Liver Disease
□ Hypertension	□ COPD	□ Previous Heart Attack	□ Lupus
□ High Cholesterol	□ Cancer	□ Sleep Apnea	□ Implanted Devices_____
□ Heart Disease	□ Mental Illness	□ Renal Disease (Kidneys)	□ Other:_____

Please list **any medications** you currently take, including anything over the counter (OTC):

Medication Name:	**Dosage:**	**Directions:**

Have you had problems with addiction or medication dependence? □ Yes □ No

Please list any known allergies:
□ No Known Drug Allergies □ Food Allergies □ Medication Allergies □ Other:
_____

Have you had any recent Hospitalizations? □ Yes □ No
If so, when and what for?_____

Please list ANY past surgical procedures and the date they occurred:
_____
_____

Have you had any recent images? □ MRI □ CT □ XRAY □ EMG □ Bone Scan

Family History:

	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer	Substance Abuse	Medication Dependence
Father							
Mother							
Maternal Grandfather							
Maternal Grandmother							
Paternal Grandfather							
Paternal Grandmother							

Social History: □ Single □ Married □ Widowed □ Divorced
Do you smoke: □Yes □No If so, how often:_____
Do you drink: □Yes □ No If so, how often:_____

Print Name	Signature	Date