1. What brings you to see us today?

2. Which area hurts the most?
(Circle the worst pain)
   a. Head
   b. Neck
   c. Shoulders
   d. Upper Back
   e. Lower Back
   f. Thighs
   g. Legs
   h. Feet

3. Mostly, where is the pain?
   a. Right side
   b. Left side
   c. Both sides

4. Do you have discomfort?
   a. All of the time
   b. Some of the time

5. What words describe your pain?
   a. Dull
   b. Aching
   c. Throbbing
   d. Stubbing
   e. Burning
   f. Shooting
   g. Pins & Needles
   h. Numbness
   i. Other

6. What aggravates your pain?
   a. Sitting
   b. Standing
   c. Walking
   d. Bending forward
   e. Leaning back
   f. Lifting
   g. Lying flat
   h. Other
   i. Nothing

7. What makes your pain better?
   a. Sitting
   b. Standing
   c. Walking
   d. Bending forward
   e. Leaning back
   f. Lying flat
   g. Ice
   h. Heat
   i. Other
   j. Nothing

8. Please draw in your area of discomfort.

   /// for pain
   xx for numbness / tingling

9. Rate your pain on this scale at NOW?
   a. No Pain
   b. 1
   c. 2
   d. 3
   e. 4
   f. 5
   g. 6
   h. 7
   i. 8
   j. 9
   k. 10

10. Rate your pain at WORST?

11. Rate your pain at BEST?

12. Overall, your pain is...
    Manageable
    Fairly well controlled
    Not well controlled

13. Do you have any associated?
    Weakness
    Dropping things
    Bowel or bladder accidents
    Skin sensitive to touch
    Skin sensitive to heat or cold
    Balance Problems
    Other

14. How long have you had this pain?
   a. since: (specific date) __/__/__
   b. for Days
   c. for Months
   d. for Years

15. Did your pain begin?
    Gradually
    Suddenly

16. How did your discomfort start? (Answer only those questions that apply)
   a. for no particular no reason
   b. after accident at home
   c. following surgery
   d. following illness
   e. Work related accident, and occurred on (date of injury) __/__/__
   f. Motor vehicle accident, and occurred on (date of injury) __/__/__
   Did you lose consciousness? No Yes
   Do you remember all details of the accident? No Yes
   Did you go to the emergency room? No Yes
   Were you able to drive your car away? No Yes
   Other

17. Have any of the following been affected by your pain? (please circle)
    Sleep
    Interest
    Guilt
    Energy
    Concentration
    Appetite
    Thoughts of Self Harm

18. Considering your pain, describe how long you can perform the following tasks:
   a. Sitting
   b. Standing
   c. Walking
   Indefinitely
   Hours
   Minutes
   Cannot tolerate

   Indefinitely
   Hours
   Minutes
   Cannot tolerate
What TESTS have you had to diagnose your pain? (please provide reports or images to the staff)

<table>
<thead>
<tr>
<th>Test</th>
<th>No</th>
<th>Yes</th>
<th>Date performed:</th>
<th>Part of Body:</th>
<th>Location Performed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-rays</td>
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<tr>
<td>MRI</td>
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<td>MRI</td>
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<td>CT Scan</td>
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<tr>
<td>Myelogram</td>
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<tr>
<td>Bone Scan</td>
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<tr>
<td>PET Scan</td>
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<tr>
<td>EMG</td>
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<tr>
<td>Other</td>
<td></td>
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</tr>
</tbody>
</table>

Have you tried any of the following procedures to TREAT your pain:

<table>
<thead>
<tr>
<th>Procedures</th>
<th>No</th>
<th>Yes</th>
<th>Level(s):</th>
<th>When:</th>
<th>Relief:</th>
<th>Long lasting</th>
<th>Short Lived</th>
<th>Some</th>
<th>NONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nerve block</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Epidural steroid injection</td>
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<tr>
<td>Radio freq. ablation</td>
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<tr>
<td>Trigger point injection</td>
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<td>Joint injection</td>
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<td>Spinal Cord Stimulation</td>
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<td>Back surgery</td>
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<tr>
<td>Neck surgery</td>
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Medications:

<table>
<thead>
<tr>
<th>Medications</th>
<th>No</th>
<th>Yes</th>
<th>Relief:</th>
<th>Long lasting</th>
<th>Short Lived</th>
<th>Some</th>
<th>NONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSAID's-Motrin, Alieve</td>
<td></td>
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<tr>
<td>Antidepressants</td>
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<tr>
<td>Oral Steroids</td>
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<tr>
<td>TENS unit</td>
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<tr>
<td>ICE or Heat</td>
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<tr>
<td>Acupuncture</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Physical Therapy              |    |     | Relief: | Long lasting | Short Lived | No improvement |
| Accupuncture                 |    |     | Relief: | Long lasting | Short Lived | No improvement |
| Massage                      |    |     | Relief: | Long lasting | Short Lived | No improvement |
| Chiropractic Care            |    |     | Relief: | Long lasting | Short Lived | No improvement |

MEDICATIONS:
Current PAIN medications (give dose, frequency, & duration used)

Current OTHER medications

Are you taking any Blood Thinners?  No  Yes

PAST PAIN medications (give dose, frequency, & duration used)

ALLERGIES: (Please be explicit.)

Allergy to CONTRAST DYE?  No  Yes

MEDICAL HISTORY: Do you have, or ever had:

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
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<tr>
<td>Lung Disease</td>
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<tr>
<td>Kidney Disease</td>
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<tr>
<td>Hypertension</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>GI problems</td>
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<tr>
<td>Eye problems</td>
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<tr>
<td>Liver disease</td>
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<tr>
<td>Bleeding disorder</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Migraines</td>
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<tr>
<td>Seizures</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>HIV/AIDS</td>
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<tr>
<td>Hepatitis</td>
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<td></td>
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<tr>
<td>Other</td>
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<td></td>
</tr>
</tbody>
</table>

SURGICAL HISTORY: (Please list all below)


**FAMILY HISTORY:** Has any of your immediate family had:
(mother, father, brothers, sisters, children)
- High blood pressure  □ No  □ Yes  WHO: ______________________
- Heart Disease  □ No  □ Yes  WHO: ______________________
- Cancer  □ No  □ Yes  WHO: ______________________
- Diabetes  □ No  □ Yes  WHO: ______________________
- Asthma  □ No  □ Yes  WHO: ______________________
- Seizures  □ No  □ Yes  WHO: ______________________
- Migraines  □ No  □ Yes  WHO: ______________________
- Tremor or Parkinson's  □ No  □ Yes  WHO: ______________________
- Depression  □ No  □ Yes  WHO: ______________________
- Other Psychiatric illness  □ No  □ Yes  WHO: ______________________
- Other (please list): ______________________

**SOCIAL HISTORY:** (please fill in as appropriate)
- Marital Status: Married  Divorced  Separated  Widowed  Single
- Substance Use Status:
  - Alcohol  □ No  □ Yes  drinks per week: ______
  - Recreational Drugs  □ No  □ Yes  type/ frequency: ______
  - Tobacco  □ No  □ Yes  packs per day: ______
  - years of smoking: ______
  - Are you interested in quitting any of the above?  □ No  □ Yes

**REVIEW OF SYSTEMS:** (circle if having)

**GENERAL**
- □ WEAKNESS
- □ TIREDNESS
- □ LACK OF APPETITE
- □ WEIGHT LOSS
- □ WEIGHT GAIN
- □ FEVER
- □ DIFFICULTY SLEEPING

**EYES, EARS, NOSE, THROAT**
- □ BLURRED VISION
- □ EYE PAIN
- □ RINGING IN YOUR EARS
- □ HOARSENESS

**CARDIOVASCULAR**
- □ CHEST PAIN, TIGHTNESS OR SQUEEZING
- □ SHORTNESS OF BREATHE LYING DOWN
- □ NEED TO SIT UP TO BREATHE
- □ HEART RACING
- □ IRREGULAR HEART BEAT (PALPITATIONS)
- □ HEART MURMUR
- □ SWELLING OF THE LEGS
- □ LEG PAIN AT REST
- □ LEG PAIN WITH EXERTION
- □ DISCOLORATION OF HANDS OR FEET

**RESPIRATORY**
- □ COUGH
- □ WHEEZING
- □ SHORTNESS OF BREATH AT REST
- □ CHEST PAIN WITH COUGH, SNEEZE, MOVEMENT

**GASTROINTESTINAL**
- □ NAUSEA
- □ VOMITING
- □ DIARRHEA
- □ CONSTIPATION
- □ HEARTBURN
- □ ABDOMINAL PAIN
- □ BRIGHT RED BLOOD IN STOOLS
- □ BLACK STOOLS
- □ CHANGE IN BOWEL HABITS
- □ NEED FOR ANTACIDS

**URINARY**
- □ URINARY TRACT INFECTIONS
- □ PAIN OR BURNING ON URINATION
- □ FREQUENT URINATION AT NIGHT
- □ STRESS INCONTINENCE OF URINE
- □ URGENCY INCONTINENCE OF URINE
- □ INABILITY TO CONTROL URINATION

**ENDOCRINE**
- □ HEAT INTOLERANCE
- □ COLD INTOLERANCE
- □ HAND TREMBLING
- □ CHANGE IN PITCH OF VOICE

**NEUROLOGIC**
- □ SEIZURES
- □ HEADACHES
- □ BLACKOUTS
- □ DIZZINESS
- □ PARALYSIS / WEAKNESS OF LIMB(S)
- □ LOSS OF SENSATION
- □ LOSS OF BALANCE
- □ LOSS OF COORDINATION
- □ SPEECH PROBLEMS

**SKIN**
- □ ITCHING
- □ RASH
- □ CHANGE IN SKIN COLOR
- □ CHANGE IN SKIN TEMPERATURE
- □ FALLING OUT OF HAIR
- □ NAIL CHANGES
- □ SKIN ULCERS

**MUSCULOSKELETAL**
- □ MUSCLE PAIN
- □ NECK OR BACK PAIN
- □ SHOULDER OR ARM PAIN
- □ RIGHT ___ LEFT
- □ PAIN DOWN YOUR LEGS
  - □ RIGHT ___ LEFT
- □ JOINT PAIN
- □ JOINT SWELLING
- □ JOINT REDNESS
- □ JOINT STIFFNESS
- □ JOINT OR EXTREMITY DEFORMITY

**PSYCHIATRIC**
- □ NERVOUSNESS
- □ DEPRESSION
- □ SLEEPING PROBLEMS
- □ EARLY MORNING AWAKENING
- □ PROBLEMS WITH MEMORY OF PAST EVENTS
- □ PROBLEMS WITH MEMORY OF RECENT EVENTS
- □ DIFFICULTY THINKING WITH PROBLEM SOLVING

**WORK STATUS:** (please answer questions that pertain to you)

- Current work status?
  - □ Full Time  □ Part Time  □ With Restrictions
  - □ Unemployed  □ Disabled  □ Retired
- If working:  What is your occupation? ______________________
- If on work restriction, describe: ______________________
- Who issued the restrictions? ______________________
- If NOT working:  When did you stop work? ___ / ___ / ___
- Why? ______________________

**LEGAL STATUS:**
- Have you pursued legal action for any injury?  □ No  □ Yes
- Regarding this current pain/discomfort?  □ No  □ Yes
<table>
<thead>
<tr>
<th>General:</th>
<th>WDWN</th>
<th>NAD</th>
<th>Body Habitus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head:</td>
<td>symmetric</td>
<td>atraumatic</td>
<td></td>
</tr>
<tr>
<td>Eyes:</td>
<td>Primary gaze intact</td>
<td>Meiosis</td>
<td>Mydriasis</td>
</tr>
<tr>
<td>Cardiovascular:</td>
<td>2 + distal pulses</td>
<td>regular in rate</td>
<td></td>
</tr>
<tr>
<td>Respiratory:</td>
<td>eased work of breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin:</td>
<td>symmetric</td>
<td>No hair loss</td>
<td>No allodynia</td>
</tr>
<tr>
<td>Neck:</td>
<td>alignment</td>
<td>tenderness</td>
<td>masses</td>
</tr>
<tr>
<td>Upper extremities:</td>
<td>alignment</td>
<td>tenderness</td>
<td>masses</td>
</tr>
<tr>
<td>Lower extremities:</td>
<td>alignment</td>
<td>tenderness</td>
<td>masses</td>
</tr>
<tr>
<td>Spine, ribs and pelvis:</td>
<td>alignment</td>
<td>tenderness</td>
<td>masses</td>
</tr>
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<td>Provocative Maneuvers:</td>
<td>Sperlings</td>
<td>Facet Loading</td>
<td>Neural/Tension</td>
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<tr>
<td>Neurological:</td>
<td>Alert and oriented to time, place and person.</td>
<td>normal affect.</td>
<td></td>
</tr>
<tr>
<td>Mental Status:</td>
<td>DTR</td>
<td>Biceps/ Triceps/ Brachioradialis</td>
<td>Hoffman’s</td>
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<tr>
<td>Reflexes: UE:</td>
<td>LE:</td>
<td>Patella/ Achilles</td>
<td>Babinski</td>
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<tr>
<td>Sensation:</td>
<td>Light touch sensation</td>
<td>Pinprick Sensation</td>
<td>Proprioception</td>
</tr>
<tr>
<td>Gait:</td>
<td>Normal gait and posture</td>
<td>normal heel to toe gait</td>
<td></td>
</tr>
<tr>
<td>Coordination:</td>
<td>Finger to nose</td>
<td>Rapid alternating movements</td>
<td></td>
</tr>
<tr>
<td>Psychiatric:</td>
<td>pain behaviors evidenced.</td>
<td>Superficial tenderness</td>
<td>Nonanatomic tenderness</td>
</tr>
<tr>
<td>Pain on rotation</td>
<td>Distracted straight leg raise</td>
<td>Regional sensory change</td>
<td>Regional weakness</td>
</tr>
</tbody>
</table>

**DX**
- □ New Prob (2) □ Est.Prob (0) □ Wup (2) □ No Wup (1)

**DATA:**
- Clinical lab test
- Reviewed today
- Ordered today
- Radiology
- Reviewed today
- Ordered today
- Discussion of results with performing physician
- Performed today
- Decision to obtain old records
- Performed today

- Obtained history from someone other than patient
- Performed today
- Discussed case with other health care provider
- Performed today
- Reviewed and summarized old records
- Performed today
- Independently visualized imaging
- Performed today

**Data Results Summarized:**

**PATIENT RISK ASSESSMENT:**
- Two or more self-limited or minor problems
- One stable chronic illness (e.g., TN, BPH, DM)
- Physical or Occupational Therapy
- Over the counter Drugs
- One or more chronic illnesses with mild exacerbation/progression
- Two or more stable chronic illnesses
- Undiagnosed new problem with uncertain prognosis
- Prescription Drug Management
- Minor Surgery with identified risk factors
- One or more chronic illnesses with severe exacerbation/progression
- Psych Illness with potential threat to self or others
- Abrupt change in neurologic status (weakness or sensory loss)
- Drug therapy requiring intensive monitoring for toxicity

**Plan:**
- □ PT
- □ Procedure
- □ Medication
- □ Medication
- □ Consultation
- □ EMG
- □ Imaging
- □ Other

- □ FU weeks: 1 2 4 8 12 24
- weeks after procedure pm none