Patient Name_____AGE_____ Referring MD_____

**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. Stabbing
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**

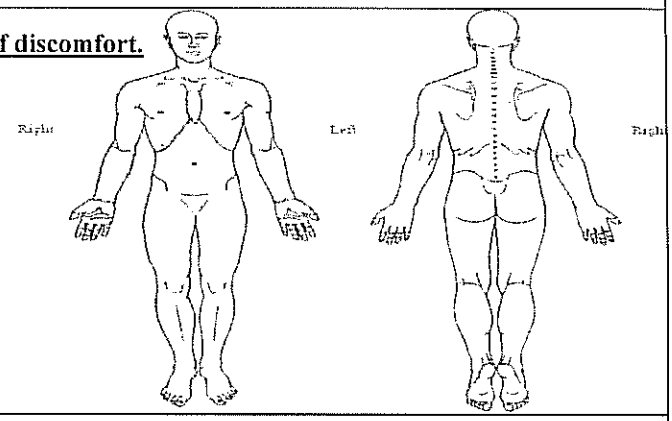
**7.What makes your pain better?**

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

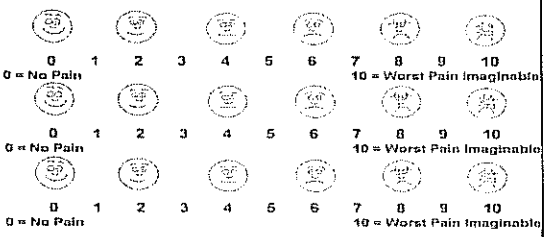
xx for numbness / tingling




**9.Rate your pain on this scale at NOW?**

**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 Balance Problems
Bowel or bladder accidents Skin sensitive to touch
Skin sensitive to heat or cold Skin color or temperature change
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
g. 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 | ☐ indefinitely | ☐ hours | ☐ minutes | ☐ cannot tolerate |
| b. | Standing | ☐ indefinitely | ☐ hours | ☐ minutes | ☐ cannot tolerate |
| c. | Walking | ☐ indefinitely | ☐ hours | ☐ minutes | ☐ cannot tolerate |

**What TESTS have you had to diagnose your pain?** (please provide reports or images to the staff)

| | | | | | |
|---|---|---|---|---|---|
| **X-rays** | ☐ No | ☐ Yes | Date performed: __/__/__ | Part of Body:_____ | Location Performed: _____ |
| **MRI** | ☐ No | ☐ Yes | Date performed: __/__/__ | Part of Body:_____ | Location Performed: _____ |
| **MRI** | ☐ No | ☐ Yes | Date performed: __/__/__ | Part of Body:_____ | Location Performed: _____ |
| **CT Scan** | ☐ No | ☐ Yes | Date performed: __/__/__ | Part of Body:_____ | Location Performed: _____ |
| **Myelogram** | ☐ No | ☐ Yes | Date performed: __/__/__ | Part of Body:_____ | Location Performed: _____ |
| **Bone Scan** | ☐ No | ☐ Yes | Date performed: __/__/__ | Part of Body:_____ | Location Performed: _____ |
| **PET Scan** | ☐ No | ☐ Yes | Date performed: __/__/__ | Part of Body:_____ | Location Performed: _____ |
| **EMG** | ☐ No | ☐ Yes | Date performed: __/__/__ | Part of Body:_____ | Location Performed: _____ |
| **Other** _____ | ☐ No | ☐ Yes | Date performed: __/__/__ | Part of Body:_____ | Location Performed: _____ |

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

Procedures

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Nerve block** | ☐ No | ☐ Yes | Level (s):_____ | When:_____ | Relief: | ☐ Long lasting | ☐ Some | ☐ NONE |
| **Epidural steroid injectn** | ☐ No | ☐ Yes | Level (s):_____ | When:_____ | Relief: | ☐ Long lasting | ☐ Some | ☐ NONE |
| **Radio freq. ablation** | ☐ No | ☐ Yes | Level (s):_____ | When:_____ | Relief: | ☐ Long lasting | ☐ Some | ☐ NONE |
| **Trigger point injection** | ☐ No | ☐ Yes | Level (s):_____ | When:_____ | Relief: | ☐ Long lasting | ☐ Some | ☐ NONE |
| **Joint injection** | ☐ No | ☐ Yes | Level (s):_____ | When:_____ | Relief: | ☐ Long lasting | ☐ Some | ☐ NONE |
| **Spinal Cord Stimulation** | ☐ No | ☐ Yes | Level (s):_____ | When:_____ | Relief: | ☐ Long lasting | ☐ Some | ☐ NONE |
| **Back surgery** | ☐ No | ☐ Yes | Level (s):_____ | When:_____ | Relief: | ☐ Long lasting | ☐ Some | ☐ NONE |
| **Neck surgery** | ☐ No | ☐ Yes | Level (s):_____ | When:_____ | Relief: | ☐ Long lasting | ☐ Some | ☐ NONE |
| **Other procedure** | ☐ No | ☐ Yes | What :_____ | When:_____ | Relief: | ☐ Long lasting | ☐ Some | ☐ NONE |

Medications:

| | | | | | | |
|---|---|---|---|---|---|---|
| **NSAID's-Motrin, Alleve** | ☐ No | ☐ Yes | Relief: | ☐ Long lasting | ☐ Short Lived | ☐ No improvement |
| **Antidepressants** | ☐ No | ☐ Yes | Relief: | ☐ Long lasting | ☐ Short Lived | ☐ No improvement |
| **Oral Steroids** | ☐ No | ☐ Yes | Relief: | ☐ Long lasting | ☐ Short Lived | ☐ No improvement |
| **TENS unit** | ☐ No | ☐ Yes | Relief: | ☐ Long lasting | ☐ Short Lived | ☐ No improvement |
| **ICE or Heat** | ☐ No | ☐ Yes | Relief: | ☐ Long lasting | ☐ Short Lived | ☐ No improvement |
| **Accupuncture** | ☐ No | ☐ Yes | Relief: | ☐ Long lasting | ☐ Short Lived | ☐ No improvement |

Other:

| | | | | | | |
|---|---|---|---|---|---|---|
| **Physical Therapy** | ☐ No | ☐ Yes | Relief: | ☐ Long lasting | ☐ Short Lived | ☐ No improvement |
| **Accupuncture** | ☐ No | ☐ Yes | Relief: | ☐ Long lasting | ☐ Short Lived | ☐ No improvement |
| **Massage** | ☐ No | ☐ Yes | Relief: | ☐ Long lasting | ☐ Short Lived | ☐ No improvement |
| **Chiropractic Care** | ☐ No | ☐ Yes | 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:

| | | | |
|---|---|---|---|
| Heart Disease | ☐ No | ☐ Yes | Details: _____ |
| Lung Disease | ☐ No | ☐ Yes | Details: _____ |
| Kidney Disease | ☐ No | ☐ Yes | Details: _____ |
| Hypertension | ☐ No | ☐ Yes | Details: _____ |
| Diabetes | ☐ No | ☐ Yes | Details: _____ |
| GI problems | ☐ No | ☐ Yes | Details: _____ |
| Eye problems | ☐ No | ☐ Yes | Details: _____ |
| Liver disease | ☐ No | ☐ Yes | Details: _____ |
| Bleeding disorder | ☐ No | ☐ Yes | Details: _____ |
| Depression | ☐ No | ☐ Yes | Details: _____ |
| Migraines | ☐ No | ☐ Yes | Details: _____ |
| Seizures | ☐ No | ☐ Yes | Details: _____ |
| Stroke | ☐ No | ☐ Yes | Details: _____ |
| Cancer | ☐ No | ☐ Yes | Details: _____ |
| HIV/AIDS | ☐ No | ☐ Yes | Details: _____ |
| Hepatitis | ☐ No | ☐ Yes | Details: _____ |
| Other | Details: _____ | | |

**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

**SOCIAL HISTORY:** (continued)

**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

**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 BREATH 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

*For Office Use Only*

| | | | | | | |
|---|---|---|---|---|---|---|
| **General**: | WDWN | NAD | Body Habitus | | | |
| **Head**: | symmetric | atraumatic | | | | |
| **Eyes**: | Primary gaze intact | Meiosis | Mydriasis | | | |
| **Cardiovascular**: | 2 + distal pulses | regular in rate | | | | |
| **Respiratory**: | eased work of breathing | | | | | |
| **Skin**: | symmetric. | No hair loss. | No allodynia. | No skin discoloration. | | |
| **Neck**: | alignment. | tenderness . | masses. | atrophy. | ROM: | 60/75/80/80 |
| **Upper extremities**: | alignment. | tenderness . | masses. | atrophy. | ROM: | Strength |
| **Lower extremities**: | alignment. | tenderness . | masses. | atrophy. | ROM: | Strength |
| **Spine, ribs and pelvis**: | alignment. | tenderness . | masses. | atrophy. | ROM: | 60/25/25/25 |
| **Provocative Maneuvers:** | Sperlings | Facet Loading | NeuralTension | | | |
| | Straight leg raise | Femoral stretch | LogRoll | Patrick's | Ganslens | Yeomans. |

**Neurological:**

| | | | | | |
|---|---|---|---|---|---|
| Mental Status: | Alert and oriented to time, place and person. | | normal affect. | | |
| Reflexes: UE: | DTR | Biceps/ Triceps / Brachioradialis | Hoffman's | Spasticity | |
| LE: | DTR | Patella/ Achilles | Babinski | Clonus | Spasticity |
| Sensation: | Light touch sensation | Pinprick Sensation | Proprioception | | |
| Gait: | Normal gait and posture | normal heel to toe gait | | | |
| Coordination: | Finger to nose | Rapid alternating movements | | | |
| **Psychiatric**: | pain behaviors evidenced. | Superficial tenderness | Nonanatomic tenderness | Axial loading | |
| Pain on rotation | Distracted straight leg raise | Regional sensory change | Regional weakness | Overreaction | |

DX_____
☐ New Prob (2)☐ Est.Prob (0)☐ Wup (2) ☐ No Wup (1)

DX_____
☐ New Prob (2)☐ Est.Prob (0)☐ Wup (2) ☐ No Wup (1)

DX_____
☐ New Prob (2)☐ Est.Prob (0)☐ Wup (2) ☐ No Wup (1)

DX_____
☐ New Prob (2)☐ Est.Prob (0)☐ Wup (2) ☐ No Wup (1)

**Plan:**
- ☐ PT _____
- ☐ Procedure _____
- ☐ Medication _____
- ☐ Medication _____
- ☐ Medication _____
- ☐ Consultation _____
- ☐ EMG _____
- ☐ Imaging _____
- ☐ Other _____

☐ FU weeks: 1 2 4 8 12 24
____weeks after procedure prn none

**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 healthcare provider | | ☐ Performed today |
| Reviewed and summarized old records | | ☐ Performed today |
| Independently visualized imaging | | ☐ Performed today |

**Data Results Summarized:**

**PATIENT RISK ASSESMENT:**
- ☐ Two or more self-limited or minor problems
- ☐ One stable chronic illness (HTN, BPH, DM)
- ☐ Physical or Occupational Therapy
- ☐ Over the counter Drugs

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- ☐ 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

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- ☐ 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