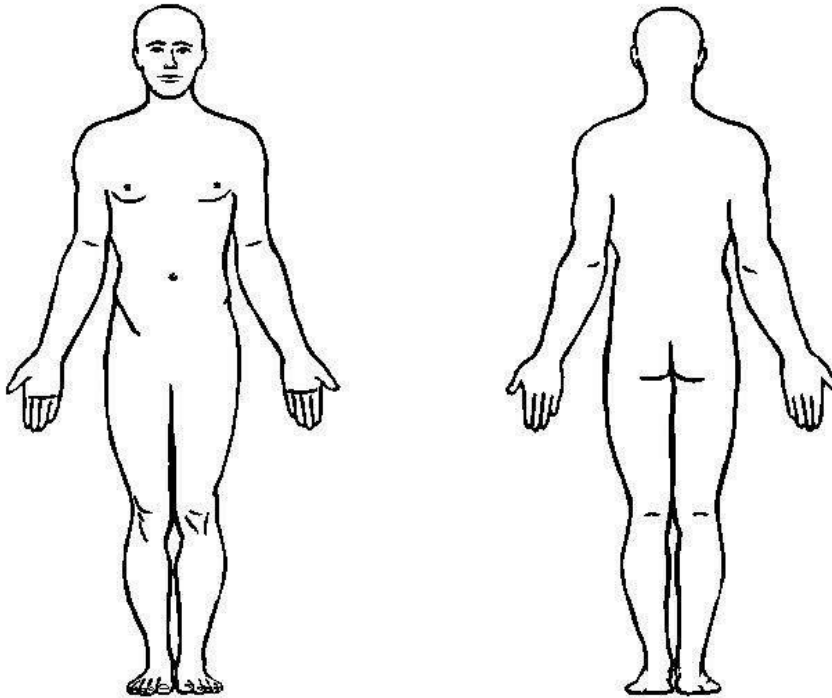




Name: _____ Today's Date: _____
 Date of Birth: _____ Age: _____ Sex: Male / Female Height: _____ Weight: _____
 Referring Physician: _____ Reason for Referral: _____

PAIN ASSESSMENT

When did your pain start? _____
 How did your pain start? _____
 If you were injured, please describe: _____
 What aggravates your pain? _____
 What relieves your pain? _____
 Describe your pain, circle all that apply, and mark the location of your pain on the body:

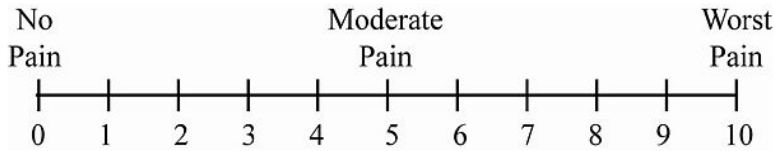


Sharp	Stabbing	Throbbing	Dull	Aching	Squeezing
Stretching	Cramping	Shooting	Localized	Diffuse	Stiff
Redness	Swelling	Heat	Immobility	Burning	Pins & Needles

Does the pain radiate anywhere? Yes / No Where? _____
 Is the pain constant or intermittent? (circle one)
 Please list any other symptoms associated with the pain: _____



What is the severity of the pain? (please circle)



Do you have the following symptoms? If yes, please describe and provide the location.

- Numbness or Tingling: _____
- Weakness: _____
- Bowel or Bladder Problems: _____

What is your activity level? _____

How far can you walk? _____ How long can you stand? _____

What are your goals? _____

PRIOR TREATMENTS

Physical Therapy? Yes / No
When? _____ Results: _____

Injections? Yes / No
What kind? (Results) _____
When? Where? Who was the Physician? _____

Surgery? Yes / No
What kind? (Results) _____
When? Where? Who was the Physician? _____

Please describe any other treatments you have tried: counseling, chiropractor, acupuncture, massage, biofeedback, other pain program: _____

Consultations – Please list all physicians you have seen concerning your pain problem. Please include their specialty, dates, and outcomes of the treatment: _____



REVIEW OF SYSTEMS

System	Symptom	Please Explain
General	Fever, Chills, Night Sweats, Unintentional Weight Loss, Fatigue, Malaise	
Eyes	Visual Changes, Double Vision, Blurry Vision, Headache, Eye Pain	
ENT	Runny Nose, Nose Bleeds, Sinus Pain, Tinnitus, Sore Throat, Painful Swallowing	
Cardiovascular	Chest Pain, Irregular Heart Rate, Exercise Intolerance, Leg Swelling	
Pulmonary	Persistent Cough, Bloody Cough, Sputum, Wheeze, Shortness of Breath	
Gastrointestinal	Abdominal Pain, Constipation, Vomiting, Diarrhea, Bloating, Bloody Stools	
Genitourinary	Incontinence, Urgency, Dysuria, Discharge, Pelvic Pain	
Musculoskeletal	Joint Pain, Muscle Pain, Stiffness, Decreased Range of Motion, Crepitus	
Integumentary	Rashes, Skin Lesions, Itchy Skin, Excessive Dryness	
Neurologic	Sensory Changes, Seizures, Headaches, Poor Balance, Speech Problems	
Psychiatric	Depression, Anxiety, Paranoia, Mania, Personality Changes	
Hematologic	Anemia, Easy Bleeding, Easy Bruising, Hemophilia, Anticoagulant Use	

PAST MEDICAL HISTORY

Do you have any drug allergies? (describe) _____

Please list all your current medical problems: _____

Do you have a pacemaker? Yes/No Is the pacemaker MRI compatible? Yes/No

Are you taking any other Blood Thinners? Yes / No Please list: _____

Please list all hospitalizations and dates: _____

Please list all prior surgeries and dates: _____

Have you had any anesthesia complications? If so, please describe: _____

Current Medications. Please list medication, dose, and prescribing physicians.

FAMILY HISTORY

Mother: Living / Deceased Health Issues: _____

Father: Living / Deceased Health Issues: _____

Children: Living / Deceased Health Issues: _____

Siblings: Living / Deceased Health Issues: _____



SOCIAL HISTORY

Are you married? YES / NO

Do you have children? YES / NO How many children and ages: _____

Do you smoke? YES / NO How many cigarettes per day: _____ How many years? _____

Do you drink alcohol? YES / NO How many drinks per day: _____

Do you currently use or have you ever used illicit drugs? YES / NO

If yes, which drugs: _____

Occupation: _____

Current Employer: _____

Highest Level of Education: _____

Patient Signature: _____

***** for office use only *****

Imaging	XR MRI CT body part:
Procedure	CESI LESI tf-ESI TPI SI Joint Injx. MBB RFA PRP Other Level: Imaging: Fluoro - U/S Sedation: local - oral - IV Location: Office - Surgery Center:
Surgery	SCS Trial SCS Implant Pump Trial Pump Implant ISS Kyphoplasty SI fusion
Referral	Neurology EMS/NCS Psych Rheum Addiction Ortho Neurosurgery PT Other
DME	LSO Traction TENS Other
Follow-up	4 weeks 8 weeks PRN Post-op Other:
Insurance	PPO HMO: _____ Medicare VA Tricare WC