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Patient Name:_____

Allergies:

☐ Penicillin ☐ Sulfa ☐ IV Dye/Contrast ☐Topical Iodine ☐Shellfish ☐Latex ☐None ☐Other:_____

Current Medications:

Medication	Dosage	Instructions

Past Medical History (check or list):

☐Aneurysm ☐Arthritis ☐Asthma ☐Blood Clots ☐Blood Pressure ☐Cancer ☐Cholesterol

☐COPD ☐Diabetes ☐Fibromyalgia ☐Heart Disease ☐Osteoporosis ☐Stroke ☐Migraine

☐Other:_____

Family Medical History (Please distinguish relationship i.e.: Mother, Father, Sibling, Grandparents…):

_____

_____

_____

Surgeries (Please list & Include Location, Date, Operating Physician):

_____

_____

_____

Social History & Occupation ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Engaged
Occupation:_____

Tobacco/Alcohol/Supplements: Tobacco: ☐Yes ☐No Frequency:_____

Alcohol: ☐Yes ☐No Frequency:_____ Coffee/Tea/Soda: ☐Yes ☐No Frequency:_____

Substance Abuse History (I.E. Marijuana, Cocaine, Narcotics, Amphetamines…)**:** Describe:_____

_____

Mental Health History: ☐Anxiety ☐Depression ☐Bipolar Disorder ☐Other:_____

Communicable Diseases: (I.E. STD's, Hepatitis, HIV/AIDS…) List:_____

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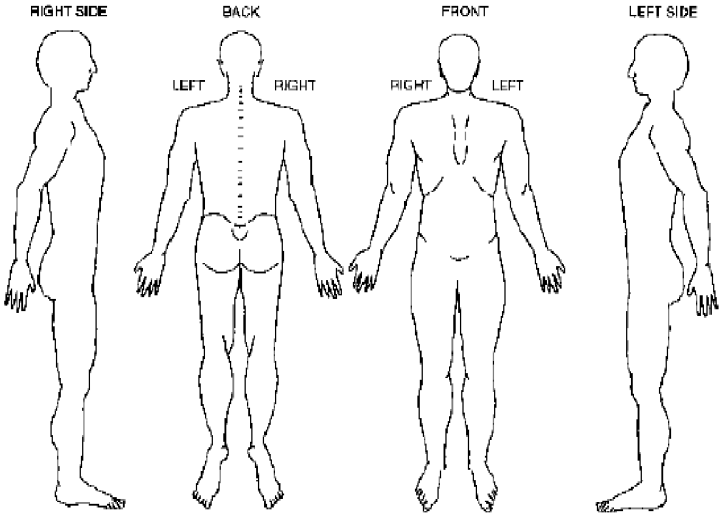
Patient Name:_____ Height:_____ Weight:_____

Mark the Areas of Pain



Check The Words That Best Describes Your Pain

☐Dull ☐Numb ☐Aching
☐Tingling ☐Sharp ☐Cramping
☐Shooting ☐Electric ☐Stabbing
☐Pulling ☐Burning
☐Throbbing
☐Radiating ☐Tearing ☐Pounding
☐Unbearable ☐Other:_____

Pain Score (check your pain score below)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain Moderate Pain Severe Pain

History of Present Illness

Are you Experiencing any Weakness? ☐Yes ☐No **What is the frequency of your pain?** ☐Constant ☐Intermittent

Are you experiencing any Loss of Bowel/Bladder Control? ☐Yes ☐No **Are you, or could you be pregnant?** ☐Yes ☐No

How long has the pain been present?_____ **How did the Injury or Pain Occur?**_____

Has your pain affected your daily activities or relationships with family or friends? ☐Yes ☐No

If Yes, please explain:_____

Is there anything that worsens the pain?

☐Bending ☐Coughing ☐Daily Activities ☐Neck Movement ☐Twisting ☐ Kneeling
☐Lifting ☐Lying Down ☐House Work ☐Prolonged Positions ☐Sitting ☐Standing
☐Sneezing ☐Stretching ☐Getting Dressed ☐Weather Changes ☐Walking ☐Stairs
☐Other:_____

Is there anything that makes the pain better?

☐Rest ☐Bending Forward ☐Bending Backward ☐Twisting ☐Massage ☐Heat ☐Ice
☐Walking ☐Switching Positions ☐Muscle Relaxant ☐Medication ☐Narcotics ☐Stretching ☐Laying

Does your Pain radiate? ☐Yes ☐No If Yes: ☐Right Arm ☐Left Arm ☐Right Leg ☐Left Leg ☐Orbit
☐Buttocks ☐Shoulder Blades ☐Other:_____

Have you missed work due to your condition? ☐Yes ☐No If so, what date?_____

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Are you currently on work restrictions? ☐Yes ☐No If yes, explain:_____

Patient Name:_____

Current/Previous Treatments:

Have you tried Therapy (Physical, Chiropractic, Occupational, or Massage Therapy)? ☐ Yes ☐No

If yes, list below the type of therapy, most recent visit, length of treatment, and length of relief

_____

_____

_____

_____

Have you tried a home exercise program? ☐Yes ☐No If yes, when did you start?_____

List below the type of exercise, duration(minutes), and frequency (times per week)

_____

_____

_____

Have you had previous Injection Therapy? ☐Yes ☐No If yes, list below (Type of Injection, Date, Length of relief)

_____

_____

_____

_____

Have you had any of the following Imaging/tests to evaluate your pain? (check all that apply)

☐MRI ☐X-Ray ☐CAT Scan ☐Bone Scan ☐EMG/Nerve Conduction ☐Vascular Studies

☐Ultrasound ☐FCE ☐Ultrasound ☐None ☐Other:_____

Please list when the test was performed, facility, and area tested:_____

_____

_____

Review of Systems

General (Constitutional)

Chills	☐Yes	☐No
Fatigue	☐Yes	☐No
Fever	☐Yes	☐No
Night Sweats	☐Yes	☐No
Weight Change	☐Yes	☐No

Neurologic

Dizziness	☐Yes	☐No
Headache	☐Yes	☐No
Seizures	☐Yes	☐No

Musculoskeletal

Back Pain	☐Yes	☐No
Joint Stiffness	☐Yes	☐No
Limb Pain	☐Yes	☐No

Hematology

Bleeding	☐Yes	☐No
Bruising	☐Yes	☐No
Anemia	☐Yes	☐No

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Patient Name:_____

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐. 9 ☐. 10 ☐. Total Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐ 9 ☐. 10 ☐. Total Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐. 9 ☐. 10 ☐. Total Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐. 9 ☐. 10 ☐. Total Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐. 9 ☐. 10 ☐. Total Disability

Self-Care: This category includes activities, which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.)

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐. 9 ☐ 10 ☐. Total Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping, and breathing.

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐. 9 ☐. 10 ☐. Total Disability

My signature confirms that the answers in this packet are accurate and stated to the best of my ability.

Patient Signature:_____Date:_____
Guardian Signature (if under 18):_____Date:_____

Pain Disability Index Total: _____