

Name: _____

Chart: _____

Date: _____

DOB: _____

Age: _____

PAIN DESCRIPTION:

***Please rate your pain using a 0-10 scale:**

_____ Your Pain Right Now?

_____ Your Worst Pain?

_____ Your Least Pain?

_____ Your Average Pain Over the Last Month?

***Pain Began:** _____ days / weeks / months / years ago
(circle one)

***Is this Pain a result of an accident or injury?**

☐ Yes (please explain _____) ☐ No

Are you currently involved in litigation?

☐ Yes (Attorney Name _____) ☐ No

***Where is your one WORST area of pain located?**

***Does this pain radiate?** ☐ Yes - where? _____ ☐ No

***Check All That Describe Your Pain Today:**

☐ Aching ☐ Shooting

☐ Burning ☐ Sharp

***Which word describes the frequency of your pain?** ☐ Constant ☐ Intermittent

***When is your pain at its worst?** ☐ Mornings ☐ During the day ☐ Evenings ☐ Middle of the night ☐ All Day

***What makes your pain worse?** ☐ Activity ☐ Bending/Twisting ☐ Sitting ☐ Standing ☐ Rest ☐ Other: _____

***What makes your pain better?** ☐ Activity ☐ Rest ☐ Medications ☐ Injections ☐ Other: _____

***Mark all of the following activities that are adversely / negatively affected by your pain:**

☐ Mood ☐ Work ☐ Sleep ☐ Activity ☐ Walking

ASSOCIATED SYMPTOMS:

***Do you have any of the following?**

☐ Balance Problems ☐ Loss of Bowel Control

☐ Numbness / Tingling - Where? _____

☐ I do not have any of the conditions below

☐ Loss of Bladder Control

☐ Weakness - Where? _____

TREATMENTS TRIED:

***Physical Therapy?** ☐ No ☐ Yes (was it helpful?) ☐ Yes ☐ No, ***Injections?** ☐ No ☐ Yes (was it helpful?) ☐ Yes ☐ No

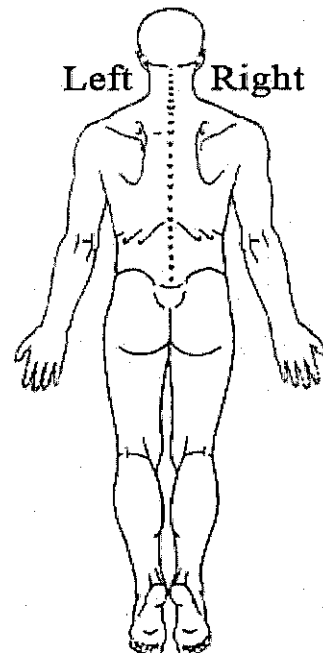
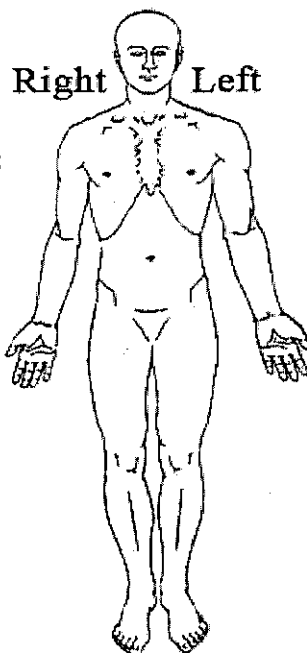
☐ Anti-inflammatories ☐ Muscle Relaxers ☐ Topical Medications ☐ Gabapentin/Lyrica ☐ Opioids

BLOOD THINNERS / PREGNANCY:

***Are you currently taking any of the following blood thinners or anticoagulants?**

☐ Aspirin ☐ NSAIDS ☐ Plavix ☐ Coumadin ☐ Xarelto ☐ Pradexa ☐ Eliquis ☐ Fish oil

***Is there any possibility of you being pregnant or becoming pregnant soon?** ☐ Yes ☐ No ☐ Male



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PAST MEDICAL HISTORY:

☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐ Bleeding Disorders ☐ Cancer (type: _____)

***Please list any other medical history:**

PAST SURGICAL HISTORY:

***Please list all surgeries and year:**

1. _____ Year: _____ 4. _____ Year: _____
2. _____ Year: _____ 5. _____ Year: _____
3. _____ Year: _____ 6. _____ Year: _____

SOCIAL HISTORY:

***Occupation:** _____ ☐ Retired ☐ Unemployed ☐ Disabled (since: _____)

***Do you drink alcohol?** ☐ Yes (number of drinks per week: _____) ☐ No ☐ Occasionally

***Do you smoke or use tobacco?** ☐ Yes (number of packs per day: _____) ☐ No ☐ Former smoker (year stopped _____)

***Living status:** ☐ alone ☐ with spouse ☐ with parents ☐ with roommate ☐ assisted living/nursing home

CURRENT MEDICATIONS:

***Please list all current medications and dose:**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES:

***Do you have any drug or metal allergies?** ☐ Yes (list) ☐ No

Patient Signature: _____

Date: _____