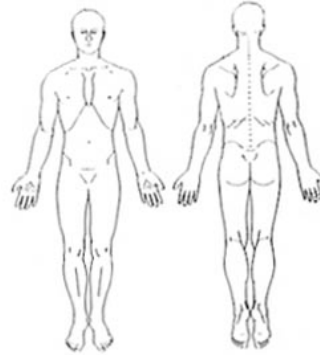




**Where is your pain located?**

- low back     left ankle/foot     head
- mid back     right ankle/foot     face
- upper back     left shoulder     other (list) \_\_\_\_\_
- neck     right shoulder
- chest     left arm
- abdomen     right arm
- groin     left hand/wrist
- left buttock     right hand/wrist
- rt. Buttock     right calf
- left thigh     left calf
- right thigh



Please shade where your pain is located

**When did you first notice your pain?**

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**Under what circumstances did your pain begin? (check one)**

- accident at work     motor vehicle accident     following surgery
- accident at home     at work, but not an accident     following illness
- pain just began, no reason     other (describe) \_\_\_\_\_

**If pain began at work, please answer the following questions:**

Place of employment where pain began \_\_\_\_\_

Date of injury: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

How long have you been employed there? \_\_\_\_\_

Type of work \_\_\_\_\_

**How did the injury occur?**

- fall     lifting     pushing
- struck by falling object     struck by object     injury from repetitive activity
- Other (describe) \_\_\_\_\_

**If pain resulted from motor vehicle accident, were you:**

- driving     passenger     driving motorcycle
- motorcycle passenger     pedestrian

Describe details \_\_\_\_\_

**When did you first see a doctor for the pain you now have?**

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**Have you been hospitalized for your pain?     yes     no**

If yes, please list:	Hospital	Dates admitted
_____	_____	_____
_____	_____	_____

**Have you had nerve blocks (injections) for pain relief?     yes     no**

If yes, by what doctor? \_\_\_\_\_ Did they relieve pain?     yes     no

If yes, how long did you get relief? \_\_\_\_\_

**Have you had an epidural?     yes     no**

If yes, by what doctor? \_\_\_\_\_ Did they relieve pain?     yes     no

If yes, how long did you get relief? \_\_\_\_\_

**Have you had tests done to evaluate your problem?**  yes  no

Test	Area tested	Date of test	Where test performed
<input type="checkbox"/> Plain X-Ray			
<input type="checkbox"/> Arthrogram			
<input type="checkbox"/> MRI			
<input type="checkbox"/> Myelogram			
<input type="checkbox"/> Bone Scan			
<input type="checkbox"/> EMG			
<input type="checkbox"/> CAT Scan			
<input type="checkbox"/> Other			

**Have you had any of the following for relief of pain?**

**Did it relieve it?**

- |                           |  |  |
|---------------------------|--|--|
| Hypnosis                  | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Biofeedback               | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Tens unit                 | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Acupuncture               | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chiropractic treatment    | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Heat therapy              | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Bedrest                   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Traction                  | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Osteopathic treatment     | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Psychotherapy/psychiatric | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Other _____               | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no |

**Since your pain began, has it:**  increased  decreased  stayed the same

**Please list all your current medications:**

Medication	Dosage	How long and for what reason	Side Effects?
_____			
_____			
_____			

**List all allergies:** \_\_\_\_\_

**Surgical History:** (check all that apply)  none

Operation	Surgeon	Where Performed	Date

**Review of Systems** (check all that apply now or in the past)

none apply

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Recent weight change            | <input type="checkbox"/> Short of breath with walking | <input type="checkbox"/> Swollen joints           | <input type="checkbox"/> Cough/wheezing       |
| <input type="checkbox"/> Blurry vision                   | <input type="checkbox"/> Swollen ankles or feet       | <input type="checkbox"/> Neck/back pain           | <input type="checkbox"/> Palpitation          |
| <input type="checkbox"/> Double vision                   | <input type="checkbox"/> Poor circulation             | <input type="checkbox"/> Leg/arm pain             | <input type="checkbox"/> Fever                |
| <input type="checkbox"/> Loss of vision                  | <input type="checkbox"/> Frequent headaches           | <input type="checkbox"/> Diarrhea/constipation    | <input type="checkbox"/> Difficulty urinating |
| <input type="checkbox"/> Blackouts/seizures              | <input type="checkbox"/> Loss of hearing              | <input type="checkbox"/> Change in bowel function |   |
| <input type="checkbox"/> Chest pain with taking a breath |   | <input type="checkbox"/> Nervous exhausting       | <input type="checkbox"/> Weight loss          |
| <input type="checkbox"/> Loss of memory                  | <input type="checkbox"/> Ringing in ears              | <input type="checkbox"/> Stomach pain             | <input type="checkbox"/> Depression/anxiety   |
| <input type="checkbox"/> Weakness of arms/legs           | <input type="checkbox"/> Difficulty swallowing        | <input type="checkbox"/> Ulcers                   | <input type="checkbox"/> Rashes               |
| <input type="checkbox"/> Poor balance                    | <input type="checkbox"/> Easy bruising/bleeding       | <input type="checkbox"/> Frequent infections      | <input type="checkbox"/> Heart/chest pain     |

