PATIENT INITIAL FORM

Today's Date: _____ **Patient's Name:** _____

Primary Care Physician: _____ **Referring Physician:** _____

Injury: □ Worker's Comp ♦ □ Motor Vehicle **Date of Accident:** _____□ **Other**_____

Describe in detail how the pain started: _____
_____
_____

Where is your pain located? □ Neck ♦ □ Upper Back ♦ □ Low Back ♦ □ Arm ♦ □ Leg
□ Shoulder ♦ □ Knee ♦ □ Hip ♦ □ Chest wall ♦ □ Headache ♦ □ Abdomen ♦ □ Other

How long have you had the pain? _____

Rate your pain No Pain (-) 0 1 2 3 4 5 6 7 8 9 0 (+) Worst Pain

How much time during an average day are you in pain? □ Few hours ♦ □ less than 1/3rd of time
□ 2/3rd of time ♦ □ all the time

Describe your pain: ♦ □ Sharp ♦ □ Burning ♦ □ Achy ♦ □ Knife-Like ♦ □ Pressure ♦ □ Heavy
□ Toothache ♦ □ Twisting ♦ □ Throbbing ♦ □ Pulsating ♦ □ Other: _____

What makes your pain worse? ♦ □ Walking ♦ □ Sitting ♦ □ Standing ♦ □ Bending ♦ □ Driving
□ Coughing ♦ □ Sneezing ♦ □ Twisting ♦ □ Other: _____

What makes your pain better? ♦ □ Heat ♦ □ Ice ♦ □ Lying down ♦ □ Sitting ♦ □ Walking
□ Bending ♦ □ Medication ♦ □ Other: _____

Are you currently receiving any type of treatment? □ Yes ♦ □ No
If so, what type? □ Spinal Injections ♦ □ Physical Therapy ♦ □ Chiropractic ♦ □ Medication
□ Ultrasound ♦ □ Massage ♦ □ Surgery ♦ □ Ice/ Heat ♦ □ Acupuncture ♦ □ Exercises
□ Other: _____

What has been done to treat this pain in the past? □ Physical Therapy ♦ □ Nerve block
□ Chiropractor ♦ □ Massage Therapy ♦ □ Water Therapy ♦ □ Trigger Point Injection ♦ □ Traction
□ Spinal Injections ♦ □ Acupuncture ♦ □ Surgery ♦ □ Other: _____

What medicines have you tried to treat this pain?♦ □ Vicodin ♦ □ Ultram ♦ □ Darvocet
□ Tylenol#3 ♦ □ Percocet ♦ □ Oxycontin ♦ □ Morphine ♦ □ Duragesic ♦ □ Elavil ♦ □ Soma
□ Flexeril ♦ □ Naprosyn /Motrin/Advil ♦ □ Neurontin ♦ □ Medrol Dosepack ♦ □ Celebrex
□ Other: _____

Medical Problems: _____
_____

Previous Surgeries: _____
_____

Current Medications: _____
_____

How much relief do you get from your medications for pain? _____

Duration of Relief: _____ **Side Effects**_____

Medication Allergies: _____

REVIEW OF SYSTEMS
(Please list any which are present)

MUSCULOSKELETAL: □ Spasms/ Cramps ♦ □ Back/ Neck/Joint Pain♦ □ Sore muscles
□ Balance Problems

NEUROLOGICAL: □ Weakness ♦ □ Numbness♦ □ Memory loss ♦ □ Pain in limb
□ Sexual Dysfunction

GASTROINTESTINAL: □ Bowel or bladder incontinence ♦ □ Speech changes ♦ □ Choking
□ Abdominal Pain

CVS/RESPIRATORY: □ Shortness of breath ♦ □ Chest pain ♦ □ Dizziness ♦ □ Fainting

PSYCHOLOGICAL: □ Depression ♦ □ Anxiety ♦ □ Irritability ♦ □ Suicidal Ideation
□ Substance Abuse

GENITOURINARY: □ Pain with urination ♦ □ Urgency ♦ □ Hesitancy ♦ □ Blood in urine

SPECIAL SENSES: □ Vision Problems ♦ □ Double Vision ♦ □ Blindness ♦ □ Hard of Hearing

FAMILY HISTORY

Is there any history of you/family (mother/father/grandparents) having/had the following:
□ Heart Attack ♦ □ Heart Failure ♦ □ High Blood Pressure ♦ □ Stroke ♦ □ Kidney Disease ♦ □ Cancer
□ Heart Catheterization ♦ □ Bleeding Problem ♦ □ Stress Test ♦ □ Hepatitis/Liver Problems
□ Pulmonary Embolus ♦ □ Blood Clotting ♦ □ Diabetes ♦Other: _____

PERSONAL / SOCIAL HISTORY / WORK / FUNCTIONAL HISTORY

Martial Status: □ Single ♦ □ Divorced ♦ □ Separated ♦ □ Widow ♦ □ Married: ___ years / ___months

List any hobbies you have: _____

Any recent weight changes? □ No ♦ □ Yes, **Gain____ lbs. Loss___ lbs. in past ____months**

I drink___ alcoholic beverages per: □ Day ♦ □ Week ♦ □ Month

I smoke ____cigarettes per: □ Day ♦ □ Week ♦ □ Month

History of drug abuse :

I get _____ hours of sleep per night **Do you have trouble falling asleep?** □ Yes ♦ □ No