Date_______________

Name: ___________________________________ **Preferred name:**________________ **DOB:**______________

DESCRIBE YOUR PAIN PROBLEM or PREVENTIVE TREATMENT GOAL

____

____

____

____

Who referred you?___________________________ **Who is your PCP**?___________________________

When did you first notice your pain? ____

When did you first seek medical attention? ____

Have you been given a diagnosis or cause of your pain?

____

What started the pain?

O Accident / Injury   O Following illness / Surgery   O Pain just began, no reason

Describe details:____

____

Is the pain work-related?   O YES   O NO

Describe details:____

____

Have you received financial compensation related to your pain?   YES   NO

Your pain at the present moment:

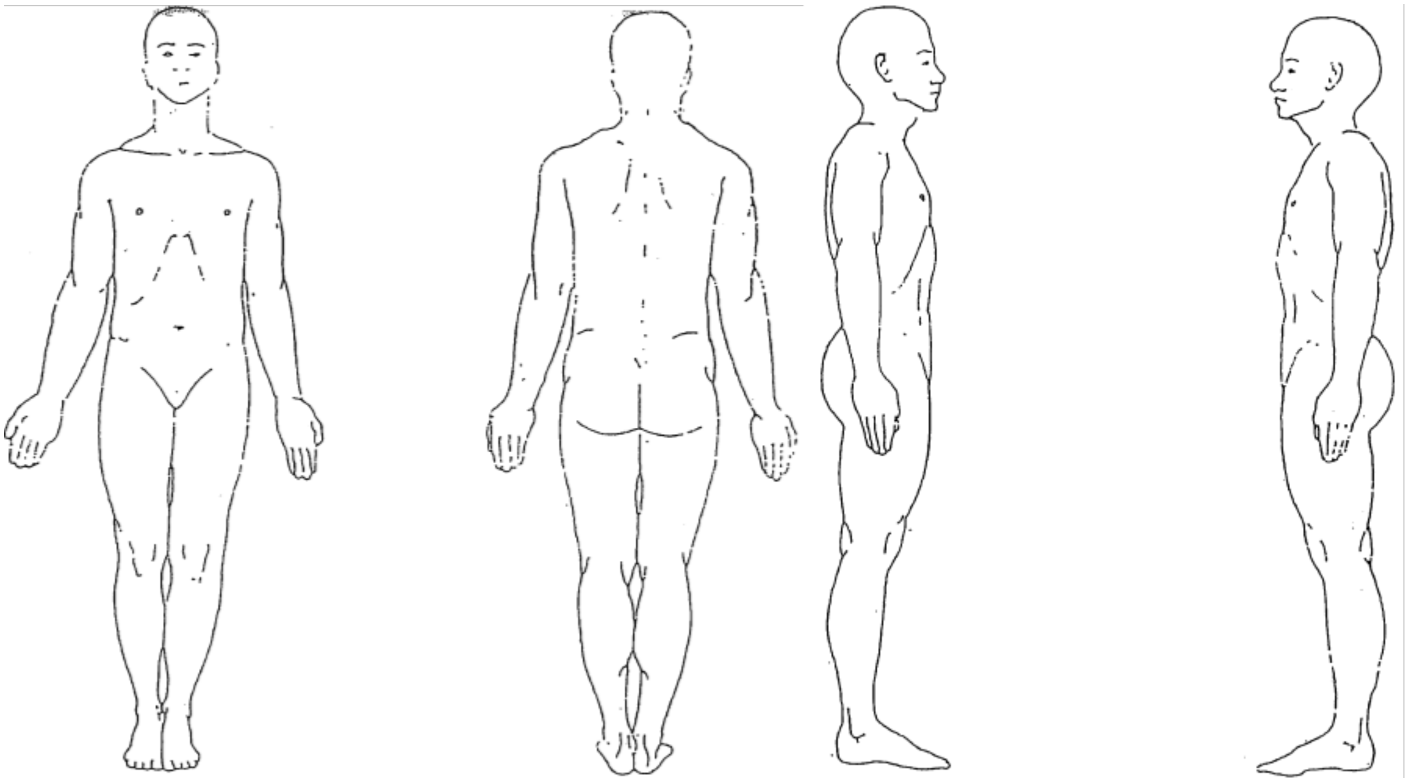
no pain 0 ———1———2———3———4———5———6———7———8———9———10 most pain

Circle the range of your pain (lowest and highest)

no pain 0 ———1———2———3———4———5———6———7———8———9———10 most pain

Indicate the areas where the pain occurs by shading on each diagram.

PLEASE BE PRECISE



Does the pain travel (radiate) anywhere? ○ YES ○ NO

Describe details:

PAIN SEVERITY

Statements that apply to your pain:

- ○ SOMETIMES PRESENT
- ○ USUALLY PRESENT
- ○ ALWAYS PRESENT
- ○ INTENSITY VARIES
- ○ ALWAYS THE SAME INTENSITY
- ○ INTERMITTENT

What time of day is your pain worst?

- ○ PAIN VARIES, NOT WORSE AT ANY PARTICULAR TIME
- ○ PAIN IS ALWAYS THE SAME
- ○ MORNING, OR ARISING
- ○ AFTERNOON
- ○ EVENING
- ○ NIGHT (DURING SLEEP HOURS)

PAIN DESCRIPTION

Would you describe your pain as (circle any that apply):

BURNING	SHARP	ACHING
TIGHT	THROBBING	PULLING
SHOOTING	STABBING	ELECTRICAL
OTHER:_________________________		

In the affected area do you have? (circle any that apply)**:**

NUMBNESS	WEAKNESS	COLDNESS
MUSCLE SPASMS, TIGHTNESS	TINGLING, PINS AND NEEDLES	INCREASED SWEATING
INCREASED SENSITIVITY TO TOUCH	SKIN COLOR CHANGES	

Do any of the following make your pain feel worse? (circle any that apply):

COUGHING, SNEEZING	STANDING	SEXUAL ACTIVITY
SITTING	WALKING	COLD
LYING DOWN	PHYSICAL ACTIVITY	OTHER:_________________________

Do any of the following ease your pain? (circle any that apply):

RELAXATION	WALKING	SITTING
PHYSICAL ACTIVITY	STANDING	SEXUAL ACTIVITY
LYING DOWN	ALCOHOLIC DRINKS	MEDICATION
HEAT	COLD	NOTHING HELPS
OTHER:_________________________		

Does pain interrupt your sleep? (choose one)

O NOT AT ALL O OCCASIONALLY O MORE THAN THREE TIMES PER NIGHT

How long can you sit? __________________________

How long can you stand? __________________________

How far can you walk without stopping? __________________________

TREATMENT HISTORY

Who have you seen?

SPECIALTY	NAME OF PROVIDER
NEUROSURGEON / SPINE SURGEON	
NEUROLOGIST	
CHIROPRACTOR	
PHYSICAL THERAPIST	
ACUPUNCTURIST	
OTHER	

Which have you had:

TESTING	DATE AND WHERE
X-RAYS	
EMG/NCS (NERVE TESTING)	
CT SCAN	
MRI SCAN	
BONE SCAN	
ULTRASOUND	
OTHER	

Have you had spine or joint injections? ○ YES ○ NO

Have you had a cell therapy? ○ PRP ○ BMC ○ ADSC ○ OTHER

BONE **M**ARROW **C**ONCENTRATE **A**DIPOSE **D**ERIVED **S**TEM **C**ELLS

Describe:____

____

Name of doctor(s) who performed injection(s):____

When was your last injection? ____

How did the injections affect your pain:

○ NO CHANGE

○ BETTER FOR A WHILE. HOW LONG?____

○RESOLVED BUT HAS RETURNED

Other therapies you have tried for relief of your pain:

THERAPY	WHEN	HELPFUL	NON HELPFUL
PHYSICAL THERAPY			
CHIROPRACTIC TREATMENT			
SUPERVISED EXERCISE			
ACUPUNCTURE			
BED REST			
TRACTION			
HEAT / COLD THERAPY			
TRIGGER POINT INJECTIONS			
BIOFEEDBACK / COUNSELING			
MASSAGE			
SCS OR PAIN PUMP			

What medications have you tried for your pain: (circle all)

NSAIDS

CELEBREX (CELECOXIB)
MOBIC (MELOXICAM)
MOTRIN, ADVIL (IBUPROFEN)
NAPROSYN (NAPROXEN)
RELAFEN (NABUMETONE)
TORADOL (KETOROLAC)
VOLTAREN (DICLOFENAC)
ASPIRIN

OPIOIDS

BUPRENORPHINE
TRAMADOL
CODEINE
HYDROCODONE
OXYCODONE
MORPHINE
HYDROMORPHONE
METHADONE
FENTANYL

NEUROPATHICS

LYRICA (PREGABALIN)
NEURONTIN (GABAPENTIN)
TOPAMAX (TOPIRAMATE)
TEGRETOL (CARBAMAZEPINE)
MEXITIL (MEXILITINE)
CLONIDINE

MUSCLE RELAXERS

BACLOFEN
FLEXERIL(CYCLOBENZAPRINE)
ZANAFLEX (TIZANIDINE)
ROBAXIN (METHOCARBAMOL)
SOMA (CARISOPRODOL)
MAGNESIUM

ANTI DEPRESSANTS

CYMBALTA (DULOXETINE)
PAMELOR (NORTRIPTYLINE)
TOFRANIL (IMIPRAMINE)
ELAVIL (AMITRIPTYLINE)
EFFEXOR (VENLAFAXINE)

STEROIDS

PREDNISONE
DEXAMETHASONE
KENALOG (TRIAMCINOLONE)
DEPOMEDROL

TOPICALS

ZOSTRIX CREAM
QUTENZA
OTC CAPSAICIN
VOLTAREN (DICLOFENAC)
LIDOCAINE

Other

NALTREXONE
MEMANTINE
KETAMINE
DESYREL (TRAZODONE)
CBD
THC

○ **STEROID PILLS OR SHOTS IN THE LAST 12 MONTHS?**____

List all medication you are currently taking.

(including nonprescription medicines and topicals)

○ I consent to the use of Surescripts® to update my current prescriptions.

MEDICATION	AMOUNT	HOW OFTEN?

Please list all medications you are allergic to.

○ **Not allergic to any drugs**

Allergic to:

____

____

____

Circle if allergic to Latex Betadine Chlorhexidine Adhesives Contrast None

Do you have a history of problems with anesthesia? ○ YES ○ NO

Describe:____

SURGICAL HISTORY

YEAR	SURGERY	SURGEON OR LOCATION

MEDICAL HISTORY

YOUR HEIGHT: ________________________________ YOUR WEIGHT: _______________________________

ARE YOU: ○ RIGHT-HANDED ○ LEFT-HANDED ○ AMBIDEXTROUS

○ GLASSES ○ HEARING AID ○ PACEMAKER ○ DEFIBRILLATOR

HIGH BLOOD PRESSURE (HYPERTENSION)

HEART DISEASE

STROKE

DIABETES

KIDNEY DISEASE

DEPRESSION / ANXIETY / PTSD

HEPATITIS OR OTHER LIVER DISEASE

ARTHRITIS

COPD. HOME O2

SLEEP APNEA

ASTHMA

GLAUCOMA

THYROID DISEASE

CANCER (___________________________________)

FREQUENT INFECTIONS

MRSA

Other:____

____

____

Are you currently working? ○ YES ○ NO

What is your occupation?____

○ Retired. Previous occupation? ____

○ Disabled. Previous occupation? ____

Who lives in your dwelling with you?____

ARE YOU: ○ SINGLE ○ MARRIED ○ DIVORCED ○ WIDOWED

Do you use tobacco:

○ NOT AT ALL

AGE YOU BEGAN SMOKING ________________

CIGARETTES PER DAY?______________

FORMER SMOKER. LAST SMOKED_________________

CHEW OR VAPE YES / NO

PIPES / CIGARS YES / NO

Do you drink alcohol:

○ NOT AT ALL

DRINKS PER DAY_________________

DRINKS PER WEEK____________

Have you used any of the below in the last year:

○ NONE

○ MARIJUANA

○ METHAMPHETAMINE

○ COCAINE

○ HEROIN / OPIOIDS- NON PRESCRIBED

OTHER____

FAMILY HISTORY

FATHER AGE______ ❑ DECEASED

HEALTH PROBLEMS:____

____

MOTHER AGE______ ❑ DECEASED

HEALTH PROBLEMS:____

____

SIBLINGS AGES________________________________ ❑ DECEASED__________________________________

HEALTH PROBLEMS:____

____

Have you had any of the following in the last 6 months?

(Circle any that apply)

GENERAL

FEVER
NIGHT SWEATS
INSOMNIA
FATIGUE
WEIGHT LOSS
WEIGHT GAIN

RESPIRATORY

TROUBLE BREATHING
WAKING UP WITH TROUBLE BREATHING
WHEEZING
PERSISTENT COUGH
COUGHING UP BLOOD
ENLARGED LYMPH NODES

HEENT

BLURRED VISION
GLASSES
RINGING IN THE EARS
SORE THROAT
DOUBLE VISION
HEARING PROBLEMS, USING A HEARING AID
NASAL DISCHARGE
EYE REDNESS

HEME

BLEEDING PROBLEMS

ALLERGY

SNEEZING
RUNNY NOSE
HAY FEVER
BURNING EYES

GI

DIARRHEA
BLOOD IN STOOLS
VOMITING UP BLOOD
ACID REFLUX / ESOPHAGITIS
CONSTIPATION
DARK, TARRY STOOLS
LOSS OF BOWEL CONTROL

SKIN

SKIN RASH
SKIN ERUPTIONS
SKIN ULCERS
ITCHING

MUSCULOSKELETAL

MUSCLE WEAKNESS
MUSCLE PAIN
MUSCLE TREMOR
SWOLLEN JOINTS

GU

HIATAL HERNIA
BLOOD IN URINE
FREQUENT URINARY TRACT INFECTION
PAIN OR BURNING ON URINATION
FREQUENT URINATION
LOSS OF BLADDER CONTROL

PSYCHIATRIC

DEPRESSION
INSOMNIA
OCD
SCHIZOPHRENIA
ANXIETY
HALLUCINATIONS
BIPOLAR DISORDER
ADD

NEUROLOGIC

HEADACHES
LOSS OF CONSCIOUSNESS
DIZZINESS/VERTIGO
FALLS
MEMORY LOSS
SEIZURES
TINNITIS

CARDIAC

DIZZINESS ON CHANGING POSITION
PALPITATIONS OR IRREGULAR HEARTBEATS
CHEST PAIN OR PRESSURE

F