PATIENT I.D. _____

Date: _____

I. PATIENT INFORMATION:

_____ _____ _____
Last Name First Name Initial

Date of Birth:_____ Age:_____ Height:_____ Weight:_____

Dominant Hand: □ Right □ Left

List and check best number where you can be reached:
- □ Home phone number:_____
- □ Cell number: _____
- □ Work number: _____

II. REFERRING DOCTOR:

_____ _____
Last Name First Name

Complete Address:

_____

_____

Phone #: _____ Fax: _____

III.* CURRENT DOCTORS: *(use the back of this page if you need more space)
List the names and COMPLETE addresses of all Health Care Practitioners you are currently seeing.

Name	Specialty	Phone	
Address	City	State	Zip
Name	Specialty	Phone	
Address	City	State	Zip

IV: UNDERSTANDING YOUR PAIN: (*Reason for visit*)

A. Describe in your own words the pain problem(s) you would like help with:

_____

_____

_____

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B. Below is a list of words that may describe your pain. Please rate each word by placing a check mark in the column that best describes the intensity of that type of pain:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Throbbing	☐	☐	☐	☐	Heavy	☐	☐	☐	☐
Shooting	☐	☐	☐	☐	Tender	☐	☐	☐	☐
Stabbing	☐	☐	☐	☐	Splitting	☐	☐	☐	☐
Sharp	☐	☐	☐	☐	Tiring-Exhausting	☐	☐	☐	☐
Cramping	☐	☐	☐	☐	Sickening	☐	☐	☐	☐
Gnawing	☐	☐	☐	☐	Fearful	☐	☐	☐	☐
Hot-Burning	☐	☐	☐	☐	Punishing-Cruel	☐	☐	☐	☐
Aching	☐	☐	☐	☐		☐	☐	☐	☐

C. Is your pain: ☐ Continuous or ☐ Intermittent*?

*If your pain is **intermittent** how often does it occur?

- ☐ Several times a day
- ☐ Once per day
- ☐ Several times per week
- ☐ Once per week
- ☐ Less than once per week
- ☐ Never
- ☐ Other

How long does your pain last?

- ☐ None
- ☐ Seconds
- ☐ Minutes
- ☐ Hours
- ☐ Days
- ☐ Weeks
- ☐ Continuous

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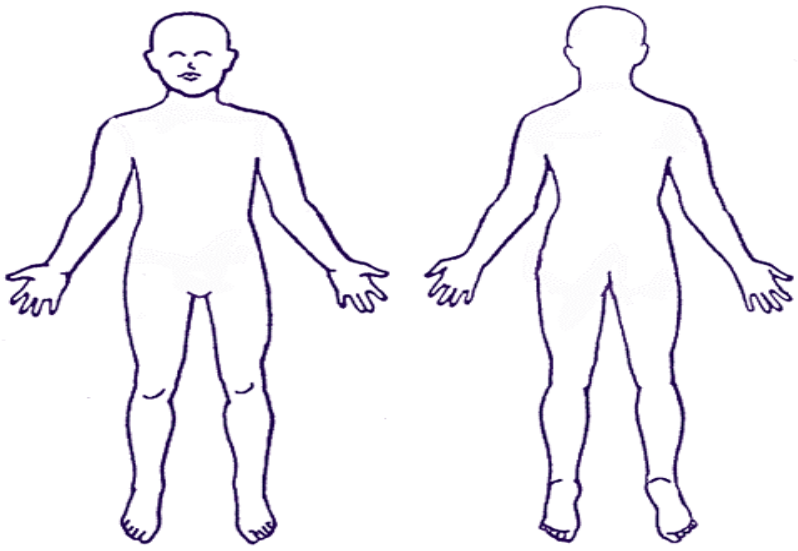
D. Circle a number below to indicate your **usual** pain intensity over the past week:

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild pain		Moderate pain			Severe pain			Most intense pain imaginable

E. Please mark areas of pain with an (X):



F. What makes the pain **WORSE?** Be Specific.

G. What makes the pain **BETTER**? Be Specific.

V. EFFECTS OF PAIN:

Circle the number to indicate how much your pain has interfered with your activities this **past week.**

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate Pain			Severe pain			Most Intense pain imaginable

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VI. CURRENT MEDICATIONS:

List **all** medicines you are **currently** taking for medical and pain problems (including prescribed, over-the-counter, herbs, vitamins): (Write on the back of this sheet if necessary)

Do not bring your medicines to the clinic unless you have a question to discuss with the physicians.

Name	Pill Strength	Number of times taken per day	Doctor who prescribed	Date Started

Pharmacy Name and Phone #_____

Address: _____ Fax# _____

VII. **HISTORY OF YOUR PAIN:**

A. When did your pain start?_____
B. When did your pain become a problem?_____
C. What event or events led to your present pain?_____

☐ Accident
☐ Cancer
☐ Other
☐ Other injury
☐ Following an operation
☐ Other Disease
☐ No obvious cause

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VII. PREVIOUS DOCTORS: List **ALL** doctors you have seen for your pain problem (*continue on the back of this page if needed*)**.**

Date	Name	Specialty	Address/Phone/Fax

IX. MRI, CT SCANS, X-RAYS:

Please list, in chronological order, all tests and x-rays performed to evaluate your pain:

Date	Test	Results

X. PREVIOUS TREATMENTS

Indicate which of the following treatments you have tried for your pain problem:

☐ Nerve Blocks ☐ Chiropractor ☐ Psychotherapy ☐ Relaxation Training
☐ Acupuncture ☐ Physical Therapy ☐ Biofeedback ☐ Exercise Program
☐ Other (list):_____

IV. PREVIOUS MEDICATIONS: List all previous pain medications you have taken for pain**:**

Name of Medicine	Dose	Dates of Use	Helpful	Reason for stopping
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

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XII. SURGERIES, HOSPITALIZATION, INJURIES:

List any operations, hospitalizations, or injuries you have ever had.

Year	**Describe** (reason for surgery / hospitalization or type of injury)	**Hospital**	**Doctor**

XIII. ALLERGIES: List all allergies to medications and the reaction you had to any medicine (or any other allergies):

Medicine	Reaction	Medicine	Reaction

XIV. REVIEW OF SYSTEMS:

Please check if you <u>now have</u> or <u>have had</u> any of the following:

A. General

- ☐ Weight Loss
- ☐ Poor appetite
- ☐ Severe fatigue / low energy
- ☐ Cancer

B. Skin

- ☐ Rash
- ☐ Nail Changes
- ☐ Bumps / nodules

C. Head and Neck

- ☐ Headaches
- ☐ Visual changes
- ☐ Mouth problems
- ☐ Neck pain
- ☐ TMJ problems

D. Hematological

- ☐ Anemia
- ☐ Easy bruising
- ☐ Bleeding disorder
- ☐ Taking blood thinners
- ☐ Blood transfusion: ☐ Yes ☐ No
  Reaction:_____

E.. Cardiac

- ☐ Exercise limitations
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Heart murmurs
- ☐ High or low blood pressure

F. Pulmonary

- ☐ Shortness of breath
- ☐ Cough
- ☐ Asthma or bronchitis
- ☐ Lung disease
- ☐ Sleep apnea
- ☐ Snoring

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REVIEW OF SYSTEMS: (Cont'd)

G. Endocrine
- ☐ Diabetes
- ☐ Thyroid problems

H. Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea or vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ History of ulcers or heartburn

I. Genitourinary
- Frequent or hesitant urination
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Sexual dysfunction

J. Gynecologic
- ☐ Pregnant
- ☐ Post-Menopausal:

Last Menstrual Period:_____

K. Musculoskeletal
- ☐ Arthritis – Type:_____
- ☐ Osteoporosis
- ☐ Muscle pain
- ☐ Muscle wasting
- ☐ Fractures

L. Neurologic
- Numbness
- ☐ Weakness
- ☐ Falling or loss of balance
- ☐ Stroke
- ☐ Seizures
- ☐ Memory Loss

M. Infectious Diseases

(check all that apply)
- ☐ Measles ☐ Mumps
- ☐ Chicken Pox
- ☐ Rheumatic fever
- ☐ Shingles
- ☐ HIV ☐ AIDS
- ☐ Herpes (oral)
- ☐ Herpes (genitals
- ☐ Post-herpetic neuralgia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other:_____

<u>In the last 5 years:</u>
Received:
Pneumovax: ☐ Yes ☐ No
Flu Shot: ☐ Yes ☐ No

N. PSYCHOLOGICAL HISTORY:

A. Describe your mood: _____

_____

B. Do you have problems with any of the following:

☐ Concentration ☐ Motivation ☐ Sleep ☐ Anxiety ☐ Depression
☐ Self-worth ☐ Homicidal thoughts ☐ Appetite ☐ Suicidal thoughts

C. Do you have a history of physical or mental abuse? ☐ Yes ☐ No

D. Are you currently in therapy? ☐ Yes* ☐ No

* If Yes, Name: _____ Degree: ☐ MD ☐ PhD ☐ MFCC

Phone #_____

How often do you see him / her?_____

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XV. HABITS:

A. Smoking: ☐ Yes ☐ No ☐ Quit Number of packs/day:____ Number of years smoked:____
B. Alcohol use: ☐ None ☐ Occasional ☐ Daily How much per week?_____
C. Recreational Drugs: Current use? ☐ Yes* ☐ No
☐ Cocaine ☐ Amphetamines ☐ Marijuana ☐ Heroin ☐ Other:_____
D. Coffee / Tea / Caffeine: Number of cups / day:_____
E. Clenching teeth: ☐ Yes ☐ No
F. Grinding teeth: ☐ Yes ☐ No
G. Do you wear a night guard over your teeth: ☐ Yes ☐ No

XVI. EXERCISE

A. Do you exercise? ☐ Yes* ☐ No
*If Yes, what type of exercise do you do?_____
B. How many days per week do you exercise?_____
C. How long do you exercise each time (on average)? _____

XVII. FAMILY HISTORY: Are you adopted? ☐ Yes ☐ No

Member	Deceased or Living		Age	Medical Problems
Father	☐	☐		
Mother	☐	☐		
Siblings	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
Spouse	☐	☐		

XVIII. SOCIAL HISTORY:

A. Relationship Status: ☐ Single ☐ Separated ☐ Married ☐ Widowed
☐ Domestic Partner: ☐ Female ☐ Male

B. With whom do you live? Name_____
Relationship: _____

C. Females (only): # of pregnancies_____ # of children_____

D. Highest level of education completed:
☐ Less than High School ☐ Vocational ☐ Graduate
☐ High School ☐ College ☐ Other: _____

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XVIII. SOCIAL HISTORY: (Cont'd)

D. What is your current employment status?
- ☐ Employed full time ☐ Employed part time ☐ Self-employed ☐ Homemaker
- ☐ Retired ☐ Unemployed due to pain
- ☐ Unemployed due to other reasons:_____

How long have you been unemployed or retired?
Are you on Disability? ☐ Yes* ☐ No
*If Yes, date disability started:_____
Reason for disability:_____
_____
_____

E. Number of hours worked per week: _____ Are you happy with your job? ☐ Yes ☐ No
Your current or most recent occupation:_____

F. Primary Language

XIX. FINANCIAL INFORMATION

Do you have any legal action pending related to this pain or any other health problem?
☐ No ☐ Yes, Attorney's name:_____ Phone #_____
Address:_____

XX. HEALTHCARE DECISIONS: (*Check boxes that apply*)
- ☐ Patient prefers to make own medical decisions.
- ☐ Medical decisions are made jointly between patient and family.
- ☐ Patient prefers family members to make the major medical decisions.
- ☐ Patient has Advance Directives: ☐ Yes* ☐ No
  *If yes, copy of Directives given to CSMC: ☐ Yes ☐ No

Source of information if other than patient:_____

Signature of person acquiring this information:_____

Signature of patient:_____ Date: _____

Evaluation reviewed by Physician:

_____	_____	_____	_____
Name of Physician (please print)	Signature of Physician	ID#	Date Signed