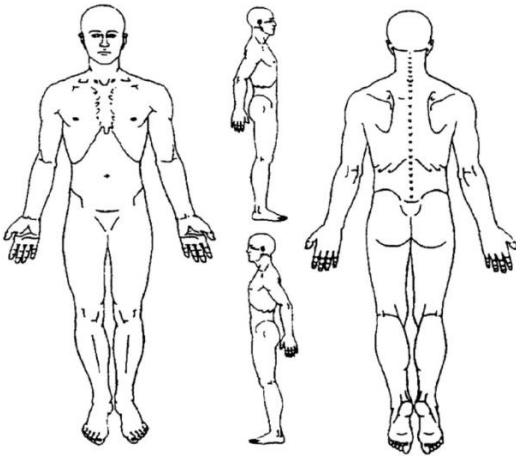


Height: \_\_\_\_\_ Weight: \_\_\_\_\_

1. Please list the three areas that cause you the most pain.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

2. Please indicate on the diagram below where your pain is located



3. Please tell us your pain story. When did your symptoms begin? (Please indicate a specific date. What happened?)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Please answer the questions below using a 0-10 scale:

\_\_\_\_\_ Your pain without medications?

\_\_\_\_\_ Your pain with medications?

5. Check all of the following that describe your pain:

- burning
- sharp
- shooting
- dull/aching
- constant
- cramping
- throbbing
- tingling
- spasm

6. As the day progresses, do your symptoms:

- worsen
- improve
- remain the same

7. Overall, has your pain/condition:

- worsen
- improve
- remain the same

8. What aggravates your symptoms?

- sitting
- standing
- up/down stairs
- walking
- sleeping
- sitting to standing
- squatting
- stress
- standing to sitting
- coughing
- bending
- household activities

9. What relieves your symptoms?

- heat
- sitting
- standing
- cold/ice
- rest
- stretching
- walking
- medication
- massage
- exercise
- lying down
- nothing
- other:

10. Check previous treatments you have had for this condition

Medications tried: Duration of therapy?

- Ibuprofen \_\_\_\_\_
- Tylenol \_\_\_\_\_
- Naproxen \_\_\_\_\_
- Tramadol \_\_\_\_\_
- Meloxicam \_\_\_\_\_
- Hydrocodone \_\_\_\_\_
- Diclofenac \_\_\_\_\_
- Oxycodone \_\_\_\_\_
- Gabapentin \_\_\_\_\_
- Morphine \_\_\_\_\_
- Lyrica \_\_\_\_\_
- Fentanyl \_\_\_\_\_
- Cymbalta \_\_\_\_\_
- Buprenorphine \_\_\_\_\_
- Nortriptyline \_\_\_\_\_
- Suboxone \_\_\_\_\_

Other Modalities Tried? When and how long were they tried?

- Physical therapy \_\_\_\_\_
- Injections \_\_\_\_\_
- Who Performed the Injections? \_\_\_\_\_
- Chiropractic care \_\_\_\_\_
- Spinal cord stimulator \_\_\_\_\_
- Psychological therapy \_\_\_\_\_

11. Have you been to a pain clinic before? If so, where and who treated your pain?

\_\_\_\_\_

### Past Surgical History

12. List any previous surgeries that you have had:

Date	Procedure

### Past Medical History

13. Please list all medical conditions you have been diagnosed with

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### Social History

14. Are you or could you be pregnant?

yes  no

15. Do you currently smoke?

yes  no Packs/day \_\_\_\_\_

16. Do you currently or have you in the past, used recreational drugs?  yes  no

If yes, when, what kind, and for how long?

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17. Do you drink alcohol?  yes  no

How many drinks per (circle)  
day/week/month?

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### Medications

Please list all prescriptions and over-the counter medications that you are currently taking. **You may attach a sperate sheet**

Medication	Strength	Dose (i.e. 1 a day)	Prescribing Physician

**Have you ever taken anti-coagulants (blood thinners) such as Coumadin, Heparin, Lovenox, Plavix, or Warfarin, Pradaxa, Eliquis, Xarelto, Aspirin, Excedrin?**

Yes, currently taking (listed above)  Yes, previously (Date last taken \_\_\_\_\_)  No, Never

**ORT**

Please check each box that applies to you.

Leave blank if not applicable

- 1. **Family History of Substance Abuse?**
  - Alcohol
  - Illegal Drugs
  - Prescription Drugs
- 2. **Personal History of Substance Abuse?**
  - Alcohol
  - Illegal Drugs
  - Prescription Drugs
- 3. **Age (Mark box if you are between 16-45)**
- 4. **History of Preadolescent Sexual Abuse**
- 5. **Psychological Disease (Mark box if any of the below applies to you)**
  - ADHD, OCD, Bipolar, Schizophrenia
  - Depression

<b>Clinic Use Only</b>	
<b>Female</b>	<b>Male</b>
1	3
2	3
4	4
3	3
4	4
5	5
1	1
3	0
2	2
1	1
<b>Total</b>	<b>Total</b>

**Review of Systems**

Please Check if you are experiencing any of the following symptoms

- Cardiovascular:**  lightheadedness  swelling in the feet  chest pain at rest
- Gastrointestinal:**  abdominal pain  constipation  nausea
- Musculoskeletal:**  neck pain  back pain  hip pain  arm pain
- muscle spasms  muscle stiffness  joint pain  leg pain
- Neurological:**  dizziness  headaches  numbness  seizures
- stroke  tingling