Provider Name: _______________ Room #: ______

Current and Past Medical History

Name________________________Date_________DOB__________Who Referred you?_________________________

Reason for visit____

DRUG ALLERGIES: ☐None

OTHER ALLERGIES: ☐None

☐Latex ☐Contrast
☐Iodine ☐Lidocaine
☐Adhesive

CURRENT MEDICATIONS: ☐None ☐See Attached

NAME	DOSE	HOW OFTEN	PHYSICIAN

HISTORY OF PAIN SYMPTOMS

Where do you have pain?

____

What does your pain feel like? □ Sharp □ Stabbing □ Dull □ Shooting □ Cramping □ Aching □ Burning □ Throbbing □Numb/Tingling □ Devastating □ Pressure □ Pulsing □ Lightning □ Crawling □

Other__________________________________

When did you pain begin?

____

Was there a specific cause?

____

Is there a certain time of day that your pain is worse? □ AM □ PM □ Other

What makes your pain worse? □ Sitting □ Standing □ Walking □ Bending □ Twisting □ Lying down □ Coughing □

Other____

What makes your pain better? □ Sitting □ Standing □ Lying down □ Rest □ Medication □ Changing positions □

Other____

Do you have any of the following: □ Numbness □ Tingling □ Weakness □ Bowel Incontinence □ Bladder Incontinence

What have you done to treat your pain?____

Physical Therapy □ No □ Yes □ When_________________________ Did it help? □ No □ Yes □ Made me worse

Chiropractic Care □ No □ Yes □ When_________________________ Did it help? □ No □ Yes □ Made me worse

Massage Therapy □ No □ Yes □ When_________________________ Did it help? □ No □ Yes □ Made me worse

Acupuncture □ No □ Yes □ When_________________________ Did it help? □ No □ Yes □ Made me worse

TENS Unit □ No □ Yes □ When_________________________ Did it help? □ No □ Yes □ Made me worse

Accpuncture □ No □ Yes □ When_________________________ Did it help? □ No □ Yes □ Made me worse

Have you had back or neck injections before? □ No □ Yes If so, what/when?

____

Have you had back or neck surgery before? □ No □ Yes If so, what/when?

____

Have your symptoms been getting worse? □ No □ Yes

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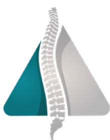
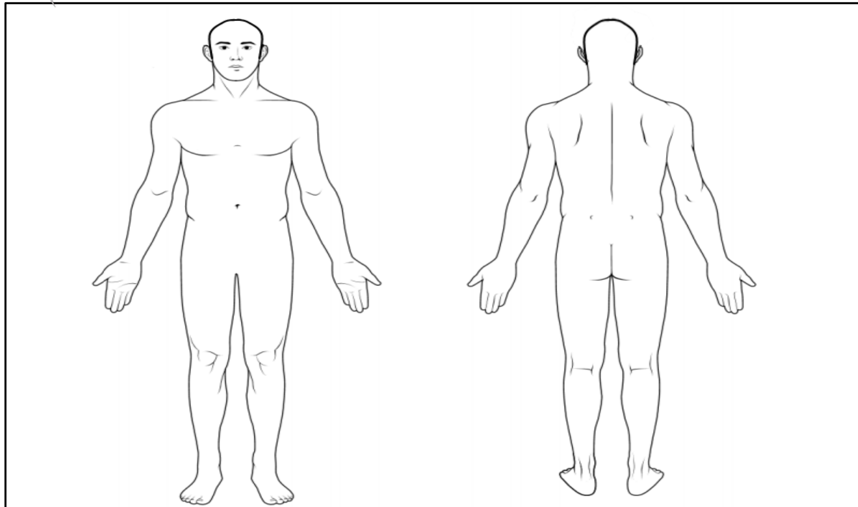


Provider Name: ______________ Room #: ______



On the drawing to the left, please indicate where you are having pain by using the symbols below to describe your symptoms:

×× Sharp/stabbing
+++ Aching/Dull
=== Burning
/// Numb or Tingling

What is today's pain: _____/10
Average pain this week: _______/10
Worst pain this week: ______/10
% relief from medications: ______%
Pain Medications Effective: □Yes □No

PLEASE INDICATE IF YOU HAVE USED OR TRIED THE FOLLOWING PAIN MEDICATIONS

□ Oxycodone	□ Hydrocodone	□ Tapentelol (Nucynta)	□ Fentanyl	□ Gabapentin	□ Cymbalta
□ Oxycontin	□ Morphine IR/ER	□ Buprenorphine (Butrans)	□ Methocarbamol (Robaxin)	□ Lyrica	□ Ibuprofen
□ Percocet	□ Hydromorphone (Dilaudid)	□ Levorphanol	□ Cyclobenzaprine (Flexeril)	□ Amitriptyline	□ Diclofenac
□ Hydrocodone	□ Exalgo (Dilaudid)	□ Methadone	□ Baclofen	□ Nortriptyline	□ Naproxen
□ Vicodin/Norco	□ Oxymorphone (Opana)	□ Subxone	□ Carisoprodol (Soma)	□ Effexor	□ Tylenol

PLEASE INDICATE IF YOU HAVE HAD THE FOLLOWING PAST MEDICAL HISTORY OR SURGERIES

Cardiac:	Endocrine:	Mental Health:	Gastrointestinal	Musculoskeletal:
☐ Coronary Artery Disease	☐ Diabetes I	☐ Depression	☐ GERD/ Ulcers	☐ Fibromyalgia
☐ High Blood Pressure	☐ Diabetes II	☐ Anxiety	☐ Crohn's Disease	☐ Chronic Fatigue
☐ High Cholesterol	☐ Hypothyroidism	☐ Bipolar Disorder	☐ Irritable Bowel Disease	☐ Osteoarthritis
☐ Heart Attacks	☐ Hyperthyroidism	☐ Schizophrenia	☐ Gallbladder Disease	☐ Rheumatoid Arthritis
☐ Arrhythmia / Pacemaker	☐ Adrenal Insufficiency	☐ ADHD	☐ Hepatitis A/B/C	□ Lupus
☐ Bypass Surgery	☐ Menopause	☐ Suicide Attempts	☐ Pancreatitis	☐ Raynaud's Disease
Neurological:	Pulmonary:	ENT:	Renal:	Hematological:
☐ MS	☐ Asthma	☐ Seasonal Allergies	☐ Kidney Failure	☐ Bleeding
☐ Stroke	☐ COPD	☐ Sinus Infection	☐ Kidney Stones	☐ Anemia
☐ Migraine HA	□ Sleep Apnea	□ Ear Infection	☐ Incontinence	☐ Leukemia
☐ Tension HA	□ Bronchitis	□ Dental Problems	☐ Urinary Tract Infection	☐ Hypercoaguable Disorder
☐ Seizures	□ Pneumonia	□ Other Problems:		
☐ Polio/Guillain-Barre	☐ Emphysema			

HAVE YOU HAD CANCER? ☐ No ☐ Yes. If yes, type/course
____

PRIOR SURGERIES:____
____

FAMILY HISTORY:

☐ Hypertension	☐ Stroke	☐ Fibromyalgia	☐ Depression	☐ Asthma	☐ Cancer. If yes, type/course
☐ High Cholesterol	☐ Migraine HA	☐ Rheumatoid Arthritis	☐ Anxiety	☐ COPD	
☐ Heart Attacks	☐ Diabetes	□ Lupus	☐ Bipolar Disorder	☐ Bleeding	

SOCIAL HISTORY:

Do you use or have you used any of the following: □ THC □ Crack □ Cocaine □ Methamphetamine □ Heroin □ Ecstasy □ PCP □ other ________________ If yes, please explain: ______________________________
Do you smoke? □ Yes □ No □ Quit □ When? _________________ Do you drink alcohol? □ Yes □ No □ Quit □ When?_________
Do you work? □ Yes □ No □ Retired □ Disabled

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS TODAY:

Constitutional:	Cardiac:	Mental Health:	Hematologic:	Integument:

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Provider Name: ______________ Room #: ______

☐ Fevers	☐ Chest Pain	☐ Depression	☐ Taking Blood Thinners	☐ Rash
☐ Chills	☐ Palpitations	☐ Anxiety	☐ Easy Bruising	☐ Hives
☐ Night Sweats	☐ Fast Heart Rate	☐ Suicidal Thoughts	☐ Excessive Bleeding	☐ Other
☐ Slow Heart Rate	☐ Slow Heart Rate	☐ Homicidal Thoughts	☐ Swollen Glands	Endocrine:
☐ Edema (Swelling)	☐ Edema (Swelling)	☐ Sleep Difficulty	☐ Other	☐ Hair Loss
☐ Weight Gain/Loss	☐ Other	☐ Restlessness	Musculoskeletal:	☐ Excessive Thirst
☐ Other	Neurological:	☐ Crying	☐ Neck Pain	☐ Other
ENT:	☐ Numbness/Tingling	☐ Agitation	☐ Low Back Pain	Gastrointestinal
☐ Hearing Difficulty	☐ Seizures	☐ Insomnia	☐ Muscle Pain	☐ Diarrhea
☐ Visual Changes	☐ Memory Impairment	☐ Other	☐ Muscle Weakness	☐ Constipation
☐ Swallowing Difficulty	☐ Weakness	Pulmonary:	☐ Morning Stiffness	☐ Nausea / Vomiting
☐ Dental Problems	☐ Incontinence	☐ Cough	☐ Joint Pain	☐ Abdominal Pain
☐ Hoarseness	☐ Loss of Balance	☐ Wheezing	☐ Joint Stiffness	☐ Jaundice
☐ Headache	☐ Loss of Coordination	☐ Shortness of Breath	☐ Difficulty walking	☐ Reflux
☐ Other	☐ Other	☐ Other	☐ Other	☐ Other

ARE YOU PREGNANT OR IS THERE A CHANCE YOU MAY BE PREGNANT? □Yes □No □NA

Patient Signature: ____ Date________________________

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