

PAIN DRAWING

PATIENT'S NAME: _____ DATE: _____

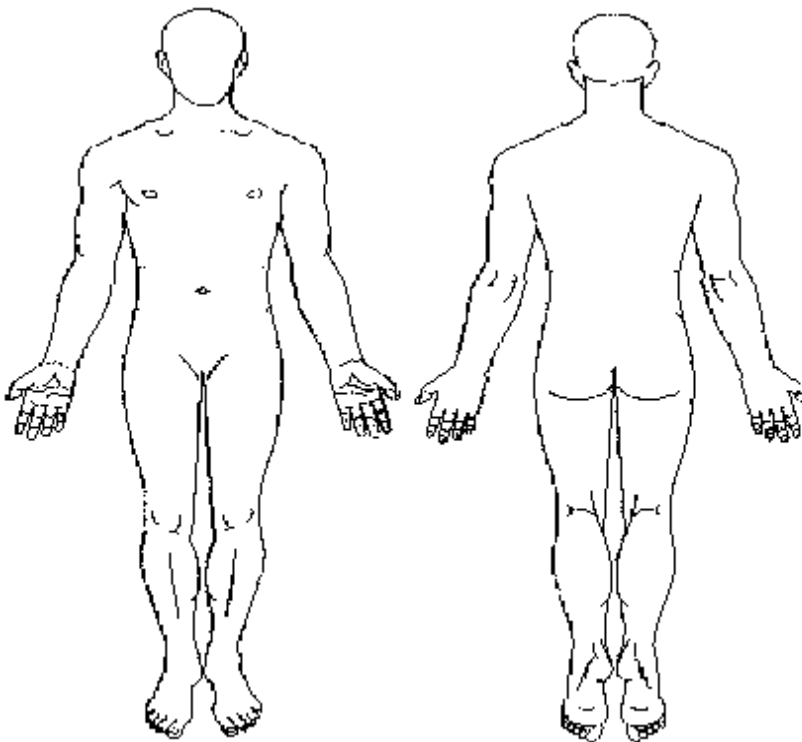
AGE: _____

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbols. Mark the areas of radiation. Include all affected areas.

ACHE	^ ^ ^	NUMBNESS	0 0 0	PINS & NEEDLES	■ ■ ■	BURNING	x x x	RADIATING PAIN	/ / /
	^ ^ ^		0 0 0		■ ■ ■		x x x		/ / /
	^ ^ ^		0 0 0		■ ■ ■		x x x		/ / /

Neck Pain _____ %
 Arm Pain _____ %
 Back Pain _____ %
 Leg Pain _____ %
 Total _____ 100%



PLEASE MARK ON THE LINE:

How bad is your pain now?

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
 NO PAIN INTERMEDIATE PAIN WORST PAIN



What position/activity makes the pain worse/better?

Position/ Activity	Worse	Better	Comments
Bending			
Bowel Movement			
Coughing			
General Activity			
Home Remedies			
Lying Down			
Sitting			
Standing			
Walking			

How long can you **STAND** with minimal or no pain ? _____ minutes

WALKING DISTANCE with minimal or no pain

0-50ft _____ 50-200ft _____ 200-500ft _____ 500+ft _____ ½ mile+ _____

Do you need **SUPPORT** to help you walk? _____ Yes _____ No

If yes, what kind of support? _____

Do you wear a back or neck **BRACE**? _____ Yes _____ No

If yes, what kind of brace? _____

List below the **CURRENT and PREVIOUS PHYSICIANS** (MD, DO, Chiropractor) you are seeing, or have seen, for your main complaint/problem:

Physician	Specialty	Dates	Treatment

Indicate which **DIAGNOSTIC TESTS** you have had in evaluation of your main complaint/problem (include dates).

Test	✓	Date	Test	✓	Date	Test	✓	Date
Plain X-Ray			EMG/NCV/SSEP			CT Scan		
Bone Scan			Arthrogram			Dexa Scan		
Myelogram			MRI			Diskogram		
Other:								

Please check which **TREATMENTS** you have had for your main problem/complaint and indicate whether they were helpful.

Treatment	✓	Helpful?	Treatment	✓	Helpful?	Treatment	✓	Helpful?
Electrical Stimulation			Massage			Whirlpool		
T.E.N.S.			Pool Exercises			Injections		
Ultrasound			Home Exercises			Acupuncture		
Hot Packs			Manipulation			Cold		
Other:			Botox					

PAST MEDICAL HISTORY Check below if you have had any of the following:

	✓	Comments		✓	Comments
Asthma			Mental Illness		
Bowel disorders			Pacemaker		
Cancer (where?)			Polio		
Depression			Psoriasis		
Diabetes		Type I or Type II	Rheumatism		
Heart disease			Seizures		
High Blood Pressure			Serious Infection		
Kidney disease			Stroke		
Lung disease			Thyroid		
Multiple myeloma			Ulcers		
Other:			Pregnancies		
			Other:		

List any **SURGERY(S)** you have had:

Type	Date	Outcome

DRUG ALLERGIES

Drug	Type of Reaction

List **ALL CURRENT MEDICATIONS** as follows (if you need additional space, please write on the back of this page)

Name	Dose (milligrams, grams)	How often (how many times a day)	How Long

Have you taken any of the following drugs previously?

Medication	✓	Helpful?	Medication	✓	Helpful?	Medication	✓	Helpful?
Aspirin			Kadian			Skelaxin		
Bextra			Lortab			Soma		
Celebrex			Mobil			Topamax		
Clinoril			Motrin			Tylenol		
Coumadin			Naprosyn			Tylenol #3		
Darvocet			Neurontin			Tylox		
Demerol			Oxycontin			Valium		
Dilaudid			Parafon Forte			Vicodin/Hydrocodone		
Dolobid			Percodan			Vioxx		
Duragesic			Plavix			Xanax		
Elavil			Prednisone			Zanaflex		
Flexeril			Prozac			Zoloft		
Ibuprofen			Relafen			Other(s)		

SOCIAL HISTORY & HABITS

Occupation _____ Marital Status _____ Highest Education Level _____

Hobbies and sport activities you enjoy: _____

WORK STATUS

Full Duty Light Duty Off-Duty per Physician Unemployed Retired

If you are working, are there any restrictions? _____ If yes, what are they _____

If you are **NOT** working full duty:

How long have you been off work? _____

Have you had a work capacity assessment? _____ Yes _____ No

Are you disabled through Social Security? _____ Yes _____ No

TOBACCO USE

Do you currently use Tobacco products? _____ Yes _____ No

Started Age/Year _____ Stopped _____

If yes, indicate the *quantity per day*:

Cigarettes _____ Cigars _____ Chewing Tobacco (snuff) _____

ALCOHOL USE

Do you currently consume alcoholic beverages? _____ Yes _____ No

If yes, indicate the *quantity per day*:

Beer _____ Wine _____ Distilled Spirits _____

Have you ever been treated for drug or alcohol addiction? _____ Yes _____ No

REVIEW OF SYSTEMS

Check if you have experienced any of the following

CONSTITUTIONAL	✓	EYES, EAR, NOSE, THROAT	▼	RESPIRATORY	✓
Weight gain - last 6 months		Recent changes in vision		Shortness of breath	
Weight loss - last 6 months		Recent changes in hearing		Cough	
Night Sweats		Recent changes in smell		Sputum	
Chills		Recent changes in taste		History of Tuberculosis	
Fever		Dizziness		Wheezing	
Fatigue					
GASTROINTESTINAL	✓	GENITO-URINARY	▼	CENTRAL NERVOUS SYSTEM	✓
Nausea / Vomiting		Blood in urine		Poor appetite	
Hepatitis		Urinary Tract infections		Problem sleeping	
Diarrhea		Unable to control bladder		Numbness/tingling feet	
Indigestion		Unable to control bowel		Numbness/tingling hands	
Abdominal pain or heartburn		Rushing to go		Crying spells	
Bloody or dark stools		Need to go frequently		Convulsions	
Peptic Ulcer					
CARDIOVASCULAR	✓	MUSCULOSKELETAL	▼	SKIN	✓
Chest pain		Cramps		Easy bleeding	
Palpitations		Attack of weakness		Any rashes	
Shortness of breath with exercise		Joint pain/swelling		Easy bruising	
Heart murmur		Morning stiffness			
Feet edema					
Abnormal Blood Pressure					

FAMILY HISTORY - Describe current health, age, cause of death illness, diabetes, cancer, hypertension, etc.

	Age	Alive	Deceased	Medical History or Cause of Death
Father				
Mother				
Child 1				
Child 2				
Child 3				
Child 4				
Child 5				
Child 6				
Sibling 1				
Sibling 2				
Sibling 3				
Sibling 4				
Sibling 5				
Sibling 6				

FEMALE PATIENTS

	Date		Date
Abnormal vaginal bleeding		History of breast biopsy	
History of nipple discharge		History of endometriosis	

Date of last **MENSTRUAL PERIOD** _____

MALE PATIENTS

	Date		Date
History of Prostatitis		Difficulty urinating	

Date of last **PROSTATIC EXAM** _____

Rectal test _____ Yes _____ No _____ Results
 PSA (Prostate blood test) _____ Yes _____ No _____ Results

The preceding patient information packet has been reviewed and discussed with my patient.

PHYSICIAN SIGNATURE _____ **Date** _____