INITIAL PAIN EVALUATION FORM

TODAY'S DATE _____/_____/_____

NAME_____ **DATE of BIRTH _____/_____/_____**

OCCUPATION_____ EMPLOYER_____

PREFERRED PHARMACY _____ FAMILY DOCTOR _____

Were you referred to us by another healthcare professional? (If yes, please state name)_____

CHIEF COMPLAINT--What is the main reason for your visit today? (Please describe your problem in detail):

_____

_____

Medical History: Do you have/had any of the following? (please circle all that apply)

Allergies to food/medicine	Mitral Valve Prolapse	Epilepsy	Tremors
Anxiety/ Depression	Hepatitis	Liver Problems	Fibromyalgia
Cancer _____(type)	Thyroid Problems	Arthritis	RA
Congestive Heart Failure	Kidney Problems	Stroke	Osteoarthritis
COPD	High Blood Pressure	Asthma	Bipolar disorder
Gastroesophageal Reflux	Diabetes	Cataracts	IBS
Headaches	Coronary Heart Disease	Gout	ADD/ADHD
Hearing Loss	Difficulty Swallowing	Heart Murmur	Other: _____
Recent Upper Respiratory Infection	Poor Leg Circulation	Pacemaker	_____
Environmental Allergies	Heart Attack	Seizures	_____

Past Surgical History: (please list any major surgeries) □ I have NEVER had any surgical procedures performed

_____

_____

_____

_____

_____

Do you have any medication allergies? (please list reaction if known) □ No Known Drug Allergies

_____

_____

_____

_____

_____

Current Medications:

Are you currently taking any blood thinners or anti-coagulants? YES NO

□Aspirin □ Plavix □ Coumadin/Warfarin □ Lovenox

□ Xarelto □ Eliquis □ Other _____

List any medications you are taking: (or bring a list of medications with to your appointment)

_____
_____
_____
_____
_____
_____
_____
_____

Family History: (please list chronic illnesses/ conditions that apply to your family members)

Mother: _____ Age deceased: _____

Father:_____ Age deceased: _____

Social History:

Occupation: _____ When was the last time you worked? _____

□Temporary Disability □ Permanent Disability □ Retired □ Unemployed

Are you currently under worker's compensation? YES NO

Is this injury due to a motor vehicle accident? YES NO

Is there an ongoing lawsuit related to your visit today? YES NO

Tobacco Use:

Do you smoke cigarettes? YES NO Packs per day _____ # of years _____

Do you use chewing tobacco? YES NO Times per day _____ # of years _____

Alcohol Use:

□ Social Use □ Daily use □ Never □ History of Alcoholism □ Current Alcoholism

Review of Systems: (check all that apply)

□Blurred Vision	□ Shortness of breath	□ Arm Numbness/ tingling	□ Weight gain
□Double Vision	□ Cough	□ Leg Numbness/tingling	□ Excessive thirst
□Headaches	□ Blood in vomit	□ Headache	□ Anxiety
□Lightheadedness	□ Abdominal Pain	□ Neck pain	□ Depression
□Neck pain	□ Can't control urine	□ Arm/ hand pain	□ Bleeding Tendencies
□Chest pain	□ Difficulty urinating	□ Back pain	□ DVT
□Leg pain while walking	□ Rash	□ Leg/ foot pain	□ Pregnant
□ Pacemaker	□ Hair Growth Change	□ Iodine Allergy	□ Contrast Dye Allergy
		□ Sciatica	□ Weight loss

Please mark all of the following treatments you have tried for pain relief:

	No Change	Worsened Pain	Relief of Pain
Spine Surgery			
Physical Therapy			
Acupuncture			
Dry Needling			
Brace Support			
Massage Therapy			
Ice/ Heat			
TENS unit			
Chiropractic Care			
Anti-inflammatories			

Interventional Pain Treatment History:

□ Epidural Steroid Injection (circle levels that apply) Cervical / Thoracic / Lumbar

□ Joint Injection (hip, sacroiliac, etc.) _____

□ Medial Branch Block/ facet injection (circle levels that apply) Cervical / Thoracic / Lumbar

□ Radiofrequency Ablation (circle levels that apply) Cervical / Thoracic / Lumbar

□ Spinal Cord Stimulator – Trial only / Permanent Implant

□ Trigger Point injections – Where? _____

□ Vertebroplasty _____

□ Spine Surgery _____

□ Other _____

Please list names of Pain Physicians/ Facilities you have seen in the past: _____

_____