

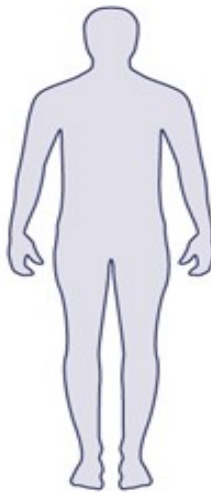
Thank you for taking the time to fill out this form. We use this form to help organize information about your problem. Please fill out as completely as possible.

Name: _____ MRN: _____
 Today's Date: _____ Referred by: _____
 Family Doctor: _____ Date of Birth: _____

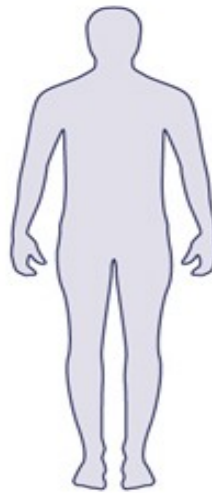
Where is your pain now?

Mark the areas on your body where you feel the sensations described above, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw your face.

- Aching**
△△△
- Numbness**
===
- Tingling**
OOO
- Pins and Needles**
+++
- Burning**
XXX
- Stabbing**
///



FRONT



BACK

Pain Rating Scale

Please make an "X" on the line that corresponds to the area of your body that you feel pain and its severity. Rate how much pain hurts on an average day by placing the "X" along the line from "No Pain" and on the left to "Worse Pain I Can Possibly Imagine" on the right.

	<u>No Pain</u>											<u>Worst Pain I Can Imagine</u>
Back Pain	_____	0	1	2	3	4	5	6	7	8	9	10
Leg Pain	_____	0	1	2	3	4	5	6	7	8	9	10
Neck Pain	_____	0	1	2	3	4	5	6	7	8	9	10
Arm Pain	_____	0	1	2	3	4	5	6	7	8	9	10

What emotional reactions have you had to your current problem? (Check all that apply.)

- I have none
- I feel like taking my life (suicidal)
- I feel nothing matters
- I feel blue and no good (depressed)
- I feel frustrated/angry
- Nothing can help me

SOCIAL HISTORY:

Marital Status: Married Single Divorced
Children: No Yes-Number and age(s) _____
I live: Alone With Someone
Alcohol Use: Yes No
If yes, how many drinks: 1-6 per week 6-12 per week 12-18 per week >18 per week
Tobacco Use: Yes No
If yes, number of packs per day: _____ number of years smoked _____

FAMILY HISTORY:

Are there any diseases that run in your family (e.g. diabetes, rheumatoid arthritis, bleeding disorders or anesthetic complications, such as malignant hyperthermia)?

Mother: Alive Deceased If deceased, cause: _____
Father: Alive Deceased If deceased, cause: _____

REVIEW OF SYSTEMS (Circle all that apply to you within the last two years):

	Explanation
Constitutional Symptoms (fever, weight loss, double vision)	
Eyes (double vision, blurring, glasses)	
Cardiovascular (chest pain, palpitations)	
Respiratory (short of breath, asthma, cough)	
Stomach/Intestinal (appetite loss, weight change, diarrhea, constipation, abdominal pain)	
Urology (hesitancy, incontinence, burning urination, menstrual problems)	
Muscular Skeletal (fracture, sprain, joint pain/swelling, arthritis)	
Skin/Breast (rashes, lesions, scars)	
Neurology (speech, swallowing problems, stroke, seizures, headaches)	
Psych (depression, hallucinations, sleep disturbances)	
Endocrine (growth/hair changes, excess thirst, decreased energy)	
Hematologic/Immunologic (easy bruising, blood clots, bleeding disorders)	

I have reviewed and fully completed all pages to the best of my ability. I understand the above statements and agree.

Patient Signature: _____ Date: _____

OFFICE USE ONLY:

MD Signature: _____ Date: _____