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Please review and complete this Medical Questionnaire and bring it with you to your first appointment.

FILL OUT BOTH FRONT AND BACK OF FORMS

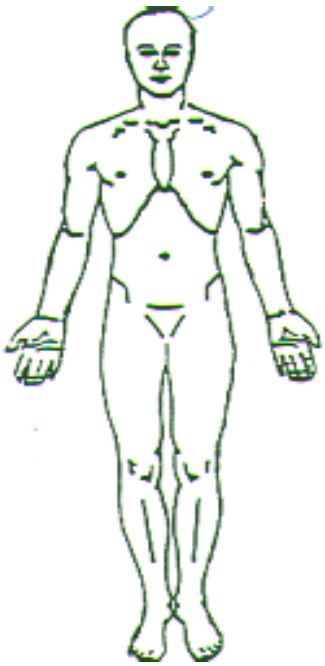
Name:		Date of Birth:
Referring Physician:	Height:	Weight:
Primary Care Provider:		
Pharmacy Information:		

Although multiple pain complaints maybe present, we will address **ONE** primary pain complaint, please briefly describe your **MAIN** pain complaint:

_____

Circle the area where you have pain, put an "X" over the area that hurts the most.

Front

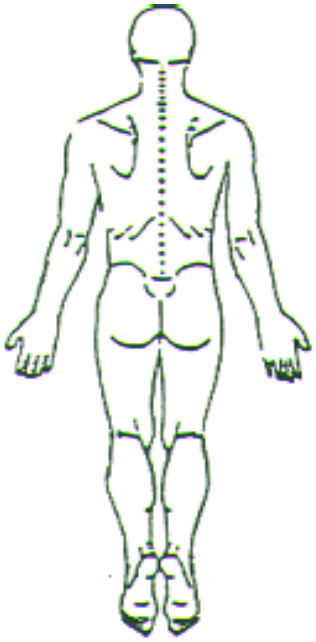


Right Left

Out of 100%, what percent of pain is on Right versus Left?

- ✓ ____% on Right
- ✓ ____% on Left

Back



Left Right

What makes the pain worse? Circle all that apply.

- ✓ Sitting
- ✓ Exercise
- ✓ Standing
- ✓ Walking
- ✓ Heat
- ✓ Bending/Twisting
- ✓ Lifting
- ✓ Cold
- ✓ Weather Changes
- ✓ Lying
- ✓ Inactivity

What makes the pain better? Circle all that apply.

- ✓ Cold
- ✓ Warm
- ✓ Shower
- ✓ Heat
- ✓ Exercise
- ✓ Relaxation
- ✓ Activity Medication

Describe your pain; Circle all that apply.

- ✓ Aching
- ✓ Shooting
- ✓ Tingling
- ✓ Numb
- ✓ Stinging
- ✓ Sharp

✓ **Circle Dominant hand:** Left Right

How did your pain begin?			
Accident at work	Date:	Auto Accident	Date:
Following Surgery	Date:	Following an Illness	Date:
Pain just Began	Date:	Other:	Date

Please rate your pain 1-10 with 10 being most severe_____

How often do you have your pain? Constant Most of the Time Occasionally Rarely

TREATMENTS

IN THE PAST 6 MONTHS.

Please check any of the following treatments that you have tried to treat your pain: NONE			
Acupuncture	Traction	Pain Clinic	Other:
Biofeedback	Exercise	Hypnosis	
Bedrest	Physical Therapy	Psychotherapy	
Chiropractor	TENS	Injection Therapy	

Please Check (√) ALL Current and Past medications you have you taken for your current pain condition.

ANALGESICS / NSAIDS	ANTIDEPRESSANTS	ANXIOLYTICS/SEDTIVES	
Acetaminophen/Tylenol Fentanyl/DURAGESIC Hydrocodone/VICODIN Hydromorphone/DILAUDID Meperidine/DEMEROL Methadone/DOLPHINE Morphine/MS CONTIN, KADIAN, AVINZA Oxycodone/OXYCONTIN, PERCOCET, TYLOX Propoxyphene/DARVOCET Tramadol/ULTRACET/ULTRAM Tylenol with codeine #2, #3, #4 Buprenorphine/BUTRANS/S UBOXONE/SUBUTEX	Celecoxib/CELEBREX Choline Magnesium Salicylate/TRILSAIE Diclofenac/VOLTAREN Diflunisal/DOLOBID Etodolac/LODINE Flurbiprofen/ANSAID Acetylsalicylic Acid/ASPIRIN Ibuprofen/MOTRIN/ADVIL Indomethacin/INDOCIN Ketoprofen/ ORUDIS Ketorolac/TORADOL Meloxicam/MOBIC Nabumetone/RELAFEN Naproxen/ALEVE Oxaprozin/DAPRO Piroxicam/FELDENE Tolmetin/TOLECTIN	Amitriptyline/ELAVIL Bupropion/WELLBUTRIN Citalopram/CELEXA Duloxetine/CYMBALTA Escitalopram/LEXAPRO Fluoxetine/PROZAC Nortriptyline/PAMLOR Paroxetine/PAXIL Sertraline/ZOLOFT Venlafaxine/EFFEXOR Quetiapine fumarate/ SEROQUEL	Alprazolam/XANAX Buspirone/BUSPAR Diazepam/VALIUM Eszopiclone/LUNESTA Flurazepam/DALMANE Haloperidol/HALDOL Hydroxyzine/ATARAX Lorazepam/ATIVAN Ramelteon/ROZEREM Temazepam/RESTORIL Triazolam/HALCION Zaleplon/SONATA Zolpidem/AMBIEN

MUSCLE RELAXANTS	ANTICONVULSANTS	OTHER MEDICATIONS TRIED FOR CURRENT PAIN
Baclofen/LIORESAL Carisoprodol/SOMA Cyclobenzaprine/FLEXERIL Metaxalone/SKELAXIN Methocarbamol/ROBAXIN Tizanidine/ZANAFLEX	Topiramate/TOPAMAX Gabapentin/NEURONTIN Levetiracetam/KEPPRA Pregabalin/LYRICA	

Allergies:
Contrast dye
Penicillin
Shellfish
Latex
Sulfa
Other:

Medical History

Do you have any of the following? Please check ALL that apply.

Hypertension	Heart attack	High Cholesterol	Asthma
Kidney disease	Seizure	Depression	Arthritis
Diabetes	Stroke	Hepatitis	Cancer
Thyroid disease	Liver disease	Lung disease	Fibromyalgia
Pacemaker	HIV	A-fib	Peripheral neuropathy
GERD	Bowel disease	Migraines	On blood thinners
Low blood sugar	Dialysis	Glaucoma	Stomach ulcer
Other:			

SURGICAL HISTORY

Have you ever had any type of surgery? Please list below		
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:

SOCIAL HISTORY

Circle appropriate response(s)

Do you smoke tobacco?	YES NO FORMER	Type used:
Packs per day?	Years smoked:	Year Quit:
Do you use oral tobacco?	YES NO FORMER	Years Used: Year Quit
Do you drink alcohol?	YES NO FORMER	Year Quit:
Type:	Amount Daily:	
Last drink?		
Do you use drugs?	YES NO PAST USEAGE	Type Used:
Do you use drugs not prescribed to you?	YES NO PAST USEAGE	Medication Name:
Currently employed?	YES NO Retired	Type of work:
Are you Disabled?	YES NO Currently applying	Disability date: Disability reason/ diagnosis:

Children?	YES NO N/A	Ages of Children: _____

	MOTHER	FATHER	SISTER	BROTHER	OTHER
Substance Abuse					
Parkinsons					
Rheumatoid Arthritis					
Ankylosing Spondylitis					
Osteoporosis					
Chiari Malformations					

Pertinent Family Medical History

Please check if any family member has had any of the following conditions:

Review of Symptoms (ROS)-Please circle any of the following experienced in the past *MONTH*.

System	Symptom (please circle)
General	Fever, Chills, Night Sweats, Unintentional Weight Loss, Fatigue, Malaise
Eyes	Visual Changes, Double Vision, Blurry Vision, Headache, Eye Pain
ENT	Runny Nose, Nose Bleeds, Sinus Pain, Tinnitus, Sore Throat, Painful Swallowing
Cardiovascular	Chest Pain, Irregular Heart Rate, Exercise Intolerance, Leg Swelling
Pulmonary	Persistent Cough, Bloody Cough, Sputum, Wheeze, Shortness of Breath
GI	Abdominal Pain, Constipation, Vomiting, Diarrhea, Bloating, Bloody Stools
Musculoskeletal	Joint Pain, Muscle Pain, Stiffness, Decreased Range of Motion, Crepitus
Integumentary	Rashes, Skin Lesions, Itchy Skin, Excessive Dryness
Neurologic	Sensory Changes, Seizures, Headaches, Poor Balance, Speech Problems
Psych	Depression, Anxiety, Paranoia, Mania, Personality Changes
Hematologic	Anemia, Easy Bleeding, Easy Bruising, Hemophilia, Anticoagulant Use

Please list medications (if you have separate list please give to front desk to make a copy)
