

PAIN MANAGEMENT QUESTIONNAIRE

Date: _____ / _____ / _____

Patient Name: _____ DOB: _____ / _____ / _____

Referring Physician: _____

Primary Care Physician: _____

Pharmacy: _____

Have you had any imaging of the area you are here to have evaluated: Yes No

If Yes, When: _____ / _____ / _____

Where: _____

Reason for appointment/Reason you were referred:

- Back Pain
 Neck Pain
 Arm/Leg Pain
 Shingles
 Abdominal Pain
 Cancer
 Headaches
 CRPS
 Other: _____

****Please fill out the rest of this form only for the pain associated with the area you marked above****

- Have you had this pain before: Yes No If Yes, When: _____
- Please describe how your pain began: _____
- Do you have weakness of your extremities: Yes No
 If Yes, Where: Left Leg Right Leg Left Arm Right Arm
- Do you have numbness (inability to feel): Yes No
 If Yes, Where: _____
- Do you have tingling: Yes No If Yes, Where: _____
- Do you have loss of control of your: Bowel Bladder
 If Yes,
 - Have you experienced this for a long time: Yes No
 - Does it only happen with coughing/sneezing: Yes No
 - Is it difficult to go: Yes No
 - Have you had any accidents: Yes No If Yes, How often: _____

Patient Name: _____

- Does the pain interrupt your sleep: Yes No

- Have you had any un-purposful Weight loss Weight gain
 If Yes, How much: _____ pounds When did this occur: _____

- Do you wake up at night sweating or soaking wet: Yes No
 If Yes, How often: _____ How long have you been experiencing: _____

- Have you been seen by another pain clinic in the past: Yes No
 If Yes, When: _____ / _____ / _____ - _____ / _____ / _____
 Who/Where: _____

- Have you had any previous pain management injections: Yes No
 If Yes, What type: _____ Did it help: Yes No
 _____ Did it help: Yes No
 _____ Did it help: Yes No

- Have you had physical therapy: Yes No
 If Yes, When: _____ / _____ / _____ - _____ / _____ / _____
 Who/Where: _____
 Did you learn a home therapy program: Yes No

- Have you seen a chiropractor: Yes No
 If Yes, When: _____ / _____ / _____ - _____ / _____ / _____
 Who/Where: _____

- Have you seen a pain psychologist: Yes No
 If Yes, When: _____ / _____ / _____ - _____ / _____ / _____
 Who/Where: _____
 Did you learn: Biofeedback Coping skills Relaxation methods

- Have you had acupuncture: Yes No
 If Yes, When: _____ / _____ / _____ Did it help: Yes No

- Have you used a TENS unit (electrical stimulation of the skin): Yes No
 If Yes, When: _____ / _____ / _____ Did it help: Yes No

Patient Name: _____

Pain Location-

On the figures below, using the symbols listed below, please mark the areas of your body where you feel:

Numbness = = = =

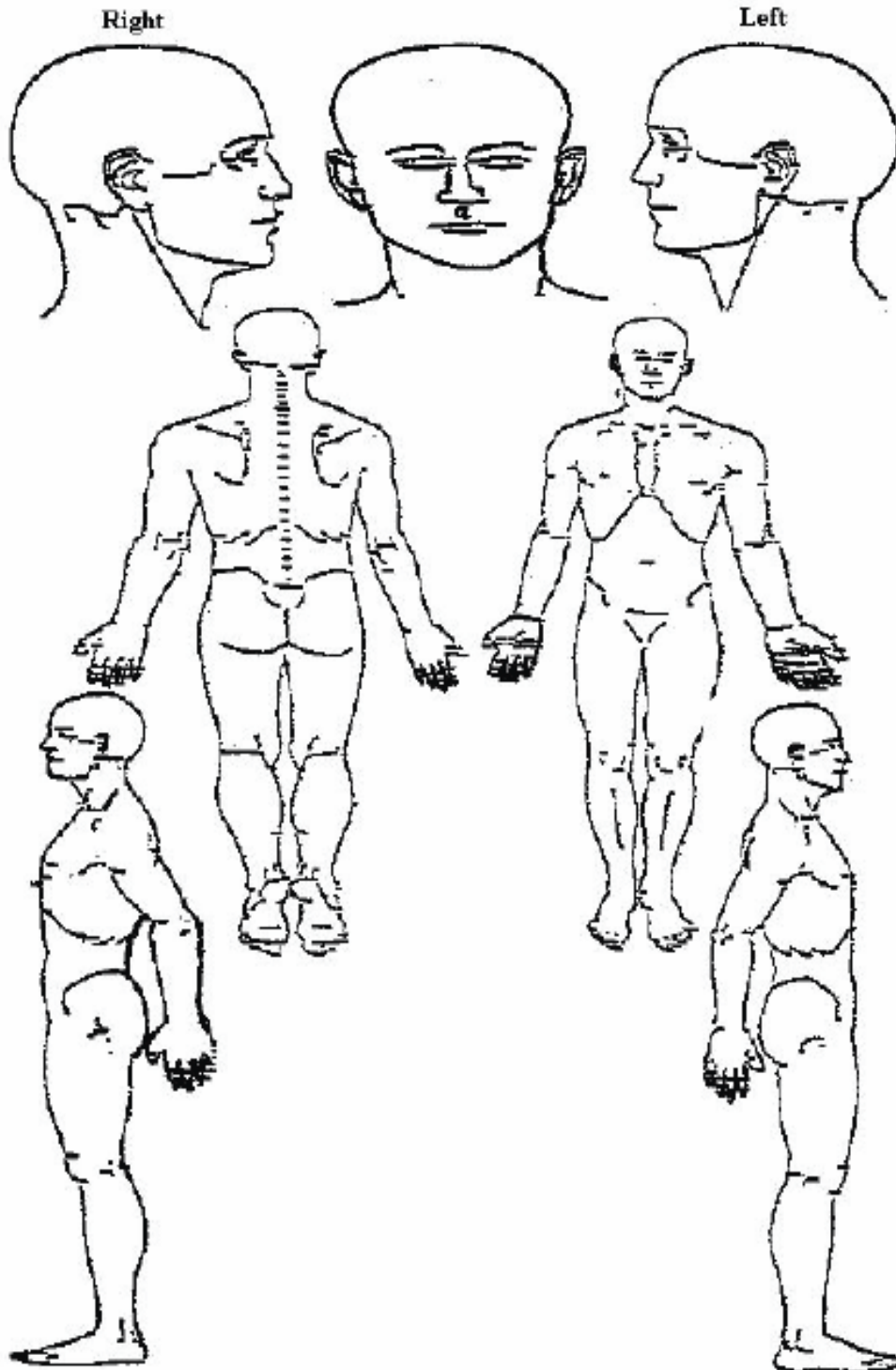
Stabbing / / / /

Burning x x x x

Pin & Needles o o o o

Aching ((((

Area where it hurts the most v



Patient Name: _____

Addressing the Personal Side of Living with Chronic Pain

As an individual living with persistent chronic pain every day, you are fully aware that your PAIN does NOT just affect you physically. Chronic pain touches every part of your life. Your pain affects you emotionally, mentally and spiritually. Living with pain has an impact on your roles in life, your relationships, your work, your hobbies, your recreational activities and the overall quality of your life. Therefore, for us to effectively address helping you manage your pain, please answer the following questions.

1. Have you struggled to manage your pain by using the “ole stiff upper lip” or “tough it out” method? Yes No
2. Have you lost your job, missed a significant amount of work or stopped physical or recreational activities? Yes No
3. Do you feel you have lost meaning and purpose in your life? Yes No
4. Has living with pain changed your roles in life as an employee, spouse, parent, etc.? Yes No
5. Do you feel you have failed or let other down by not being able to “DO” as you once did? Yes No
6. Do you feel your pain is often in control of your life:? Yes No
7. Do you find your moods bouncing around, at times you feel depressed, angry or anxious? Yes No
8. Do family/friends seem to struggle to understand what it is like for you to live with chronic pain? Yes No
9. Do you feel judged at times? Yes No
10. Do you struggle sometimes making a decision about an activity worrying that it will result in a “flare up”? Yes No
11. Have you noticed that as your stress level increases so does your pain? Yes No
12. Do you find it difficult to “relax” or “calm” yourself as you go through your day with pain? Yes No

Please share with us any comments you have regarding the screening questions or any personal concerns or difficulties you have living with your pain:

Patient Name: _____

BACK PAIN



- Is your walking limited: Yes No

If yes, how far can you walk without stopping to rest: _____ blocks / miles

- Does bending over holding on to a shopping cart, etc. allow you to walk farther: Yes No

- What percentage in in the back: _____% What percentage is in the leg(s): _____%

Please check all that apply.

Concern: <input type="text" value="back pain"/>		Status:		Frequency:		 			
Onset: <input type="text"/>		Severity: <input type="text"/>		<input type="radio"/> Changing <input type="radio"/> Improving <input type="radio"/> Fluctuating <input type="radio"/> Resolved <input type="radio"/> Stable <input type="radio"/> Worse		<input type="radio"/> Intermittently <input type="radio"/> Occasional <input type="radio"/> Persistent <input type="radio"/> Rare			
Duration: <input type="text"/>		Location of Pain:		Radiation of Pain:		Quality:		Context: (what caused onset of pain)	
<input type="checkbox"/> Upper back <input type="checkbox"/> Neck <input type="checkbox"/> Mid back <input type="checkbox"/> Thighs <input type="checkbox"/> Lower back <input type="checkbox"/> Gluteal area <input type="checkbox"/> Left flank <input type="checkbox"/> Right flank <input type="checkbox"/> Arms <input type="checkbox"/> Legs Other: <input type="text"/>		<input type="checkbox"/> None <input type="checkbox"/> Back <input type="checkbox"/> Dermatologically anterior <input type="checkbox"/> Left ankle <input type="checkbox"/> Right ankle <input type="checkbox"/> Left arm <input type="checkbox"/> Right arm <input type="checkbox"/> Left calf <input type="checkbox"/> Right calf <input type="checkbox"/> Left foot <input type="checkbox"/> Right foot <input type="checkbox"/> Left thigh <input type="checkbox"/> Right thigh Other: <input type="text"/>		<input type="checkbox"/> Ache <input type="checkbox"/> Piercing <input type="checkbox"/> Burning <input type="checkbox"/> Sharp <input type="checkbox"/> Deep <input type="checkbox"/> Shooting <input type="checkbox"/> Diffuse <input type="checkbox"/> Stabbing <input type="checkbox"/> Discomforting <input type="checkbox"/> Superficial <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Localized <input type="checkbox"/> Numbness Other: <input type="text"/>		<input type="checkbox"/> Bending forward <input type="checkbox"/> Pulling <input type="checkbox"/> Bending over <input type="checkbox"/> Pushing <input type="checkbox"/> Blow from behind <input type="checkbox"/> Sitting <input type="checkbox"/> Hard fall <input type="checkbox"/> Sports: <input type="text"/> <input type="checkbox"/> Inflamm bowel disease <input type="checkbox"/> Sudden movement <input type="checkbox"/> Lifting a heavy object <input type="checkbox"/> Trauma <input type="checkbox"/> Lying down <input type="checkbox"/> Twisting movement <input type="checkbox"/> MVA <input type="checkbox"/> Walking <input type="checkbox"/> No injury <input type="checkbox"/> Walking up stairs Other: <input type="text"/>			
Trauma: Type: <input type="text"/> Where: <input type="text"/> When: <input type="text"/> Date: <input type="text"/> / / <input type="checkbox"/> Previously injured		Aggravated By:		Relieved By:					
		<input type="checkbox"/> Nothing <input type="checkbox"/> Ascending stairs <input type="checkbox"/> Extension <input type="checkbox"/> Bending <input type="checkbox"/> Flexion <input type="checkbox"/> Changing positions <input type="checkbox"/> Jumping <input type="checkbox"/> Coughing <input type="checkbox"/> Lifting <input type="checkbox"/> Daily activities <input type="checkbox"/> Lying/rest <input type="checkbox"/> Defecation <input type="checkbox"/> Rolling over in bed <input type="checkbox"/> Descending stairs <input type="checkbox"/> Pushing Other: <input type="text"/>		<input type="checkbox"/> Nothing <input type="checkbox"/> Exercise <input type="checkbox"/> Lying down <input type="checkbox"/> Heat <input type="checkbox"/> Massage <input type="checkbox"/> Ice <input type="checkbox"/> Movement <input type="checkbox"/> Injection: <input type="checkbox"/> OTC medications: <input type="checkbox"/> Pain meds/drugs <input type="checkbox"/> Physical therapy <input type="checkbox"/> Spontaneously <input type="checkbox"/> Stretching <input type="checkbox"/> Rest <input type="checkbox"/> Sitting Other: <input type="text"/>					

Patient Name: _____

ABDOMINAL PAIN

Please check all that apply.



Abdominal Pain Quick Visit		Severity of Symptoms		<input type="radio"/> mild	<input type="radio"/> moderate	<input type="radio"/> severe	<input type="radio"/> incapacitating		
Concern <input type="text" value="abdominal pain"/>		Onset <input type="text"/>	Frequency	<input type="radio"/> constant	<input type="radio"/> recurring	<input type="radio"/> intermittent	<input type="radio"/> nocturnal		
Pain Scale <input type="text"/>		Status	<input type="radio"/> improving	<input type="radio"/> no change	<input type="radio"/> worse	<input type="radio"/> resolved			
Location		Radiation		Quality		Context (what caused onset of pain)			
<input type="checkbox"/> diffuse <input type="checkbox"/> right upper quadrant <input type="checkbox"/> epigastric <input type="checkbox"/> right lower quadrant <input type="checkbox"/> hypogastric <input type="checkbox"/> left upper quadrant <input type="checkbox"/> midline <input type="checkbox"/> left lower quadrant <input type="checkbox"/> peri-umbilical other <input type="text"/>		<input type="checkbox"/> back <input type="checkbox"/> pelvis <input type="checkbox"/> chest <input type="checkbox"/> perineum <input type="checkbox"/> flank <input type="checkbox"/> rectum <input type="checkbox"/> groin <input type="checkbox"/> shoulder <input type="checkbox"/> neck other <input type="text"/>		<input type="checkbox"/> achy <input type="checkbox"/> sharp <input type="checkbox"/> burning <input type="checkbox"/> stabbing <input type="checkbox"/> colicky <input type="checkbox"/> throbbing <input type="checkbox"/> dull other <input type="text"/>		No Yes <input type="radio"/> after bowel movement <input type="radio"/> recent foreign travel <input type="radio"/> after meals <input type="radio"/> menses other negatives <input type="text"/> <input type="radio"/> on urination other positives <input type="text"/> <input type="radio"/> recent antibiotic use comments <input type="text"/>			
Aggravated by		<input type="checkbox"/> nothing		Relieved by		<input type="checkbox"/> nothing			
No Yes <input type="radio"/> alcohol <input type="radio"/> exercise <input type="radio"/> anxiety <input type="radio"/> intercourse <input type="radio"/> bowel movement <input type="radio"/> milk / dairy products <input type="radio"/> constipation <input type="radio"/> movement other negatives <input type="text"/> other positives <input type="text"/> comments <input type="text"/>				No Yes <input type="radio"/> analgesics <input type="radio"/> H2 blockers <input type="radio"/> antacids <input type="radio"/> OTC meds <input type="radio"/> bowel movement <input type="radio"/> proton pump inhibitors <input type="radio"/> change in position <input type="radio"/> rest <input type="radio"/> eructation <input type="radio"/> vomiting other negatives <input type="text"/> other positives <input type="text"/> comments <input type="text"/>					
Associated Symptoms / Pertinent Negatives									
Neg Pos <input type="radio"/> back pain <input type="radio"/> diaphoresis <input type="radio"/> bloating <input type="radio"/> diarrhea <input type="radio"/> blood in stool <input type="radio"/> dizziness <input type="radio"/> change in appetite <input type="radio"/> dyspnea <input type="radio"/> constipation <input type="radio"/> eructation		Neg Pos <input type="radio"/> fever <input type="radio"/> flank pain <input type="radio"/> flatulence <input type="radio"/> heartburn <input type="radio"/> hematuria		Neg Pos <input type="radio"/> jaundice <input type="radio"/> lightheadedness <input type="radio"/> myalgia <input type="radio"/> nausea <input type="radio"/> rash		Neg Pos <input type="radio"/> vaginal bleeding <input type="radio"/> vaginal discharge <input type="radio"/> vomiting <input type="radio"/> weight gain <input type="radio"/> weight loss other negatives <input type="text"/> other positives <input type="text"/> comments <input type="text"/>			
Comments <input type="text"/>									
Review of Systems									
Constitutional	Neg Pos	Gastrointestinal	Neg Pos	Gastrointestinal	Neg Pos	Genitourinary	Neg Pos	Reproductive	Neg Pos
chills / rigors	<input type="radio"/> <input type="radio"/>	abdominal pain	<input type="radio"/> <input type="radio"/>	melena	<input type="radio"/> <input type="radio"/>	dysuria	<input type="radio"/> <input type="radio"/>	dysmenorrhea	<input type="radio"/> <input type="radio"/>
fatigue	<input type="radio"/> <input type="radio"/>	anorexia	<input type="radio"/> <input type="radio"/>	nausea	<input type="radio"/> <input type="radio"/>	flank pain	<input type="radio"/> <input type="radio"/>	dyspareunia	<input type="radio"/> <input type="radio"/>
fever	<input type="radio"/> <input type="radio"/>	constipation	<input type="radio"/> <input type="radio"/>	reflux	<input type="radio"/> <input type="radio"/>	frequent urination	<input type="radio"/> <input type="radio"/>	menorrhagia	<input type="radio"/> <input type="radio"/>
		diarrhea	<input type="radio"/> <input type="radio"/>	vomiting	<input type="radio"/> <input type="radio"/>	hematuria	<input type="radio"/> <input type="radio"/>	vaginal discharge	<input type="radio"/> <input type="radio"/>
		hematemesis	<input type="radio"/> <input type="radio"/>	weight loss	<input type="radio"/> <input type="radio"/>				
		hematochezia	<input type="radio"/> <input type="radio"/>						
								<input type="button" value="OK"/>	<input type="button" value="Cancel"/>

Patient Name: _____

NECK PAIN

- What percentage in in the neck: _____%
- What percentage is in the arm(s): _____%

Please check all that apply.

Concern: <input type="text" value="neck pain"/>		Severity: <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> Incapacitating <input type="radio"/> Other	Status: <input type="radio"/> Improved <input type="radio"/> No change <input type="radio"/> Worse <input type="radio"/> Resolved <input type="radio"/> Other	Frequency: <input type="radio"/> Constant <input type="radio"/> Intermittent <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Other	 
Onset: <input type="text"/>	<input type="button" value="i"/>				
Duration: <input type="text"/>	<input type="button" value="i"/>				
Location: <input type="checkbox"/> No pain	Radiation: <input type="checkbox"/> None	Quality:	Context (what caused onset of pain)	Trauma:	
Head: <input type="radio"/> R <input type="radio"/> L <input type="radio"/> B	Head: <input type="radio"/> R <input type="radio"/> L <input type="radio"/> B	<input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Discomforting <input type="checkbox"/> Dull <input type="checkbox"/> Gnawing <input type="checkbox"/> Lancinating <input type="checkbox"/> Piercing <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Tingling	<input type="radio"/> No <input type="radio"/> Yes <input type="checkbox"/> Axial loading <input type="checkbox"/> Bending over <input type="checkbox"/> Blow from behind <input type="checkbox"/> Cervical compression <input type="checkbox"/> Driving off-road <input type="checkbox"/> Hard fall <input type="checkbox"/> Hyperflexion <input type="checkbox"/> Injury <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down	Type: <input type="text"/> Where: <input type="text"/> When: <input type="text"/> Date: <input type="text" value=" / /"/> <input type="checkbox"/> Previously injured	
Other: <input type="text"/>	Other: <input type="text"/>	Other: <input type="text"/>	Other positives: <input type="text"/>	Other negatives: <input type="text"/>	
Aggravated By:		Relieved By:			
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Bending <input type="checkbox"/> Climbing stairs <input type="checkbox"/> Coughing <input type="checkbox"/> Defecation <input type="checkbox"/> Driving <input type="checkbox"/> Exertion <input type="checkbox"/> Flexion <input type="checkbox"/> Hyperextension <input type="checkbox"/> Kneeling	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down <input type="checkbox"/> Prolonged sitting <input type="checkbox"/> Pushing <input type="checkbox"/> Rotation <input type="checkbox"/> Running Other positives: <input type="text"/> Other negatives: <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Sneezing <input type="checkbox"/> Standing <input type="checkbox"/> Stopping <input type="checkbox"/> Straining <input type="checkbox"/> Stress <input type="checkbox"/> Turning head	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Twisting <input type="checkbox"/> Valsalva <input type="checkbox"/> Walking <input type="checkbox"/> Working <input type="checkbox"/> Nothing	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Acupuncture <input type="checkbox"/> Cervical collar <input type="checkbox"/> Cervical traction <input type="checkbox"/> Cold compresses <input type="checkbox"/> Exercise <input type="checkbox"/> Heating pad <input type="checkbox"/> Ice <input type="checkbox"/> Injection <input type="checkbox"/> Lateral bending	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Manipulation <input type="checkbox"/> Massage <input type="checkbox"/> Muscle relaxation techniques <input type="checkbox"/> Narcotic/analgesics <input type="checkbox"/> NSAIDs <input type="checkbox"/> OTC meds <input type="checkbox"/> Physical therapy <input type="checkbox"/> Rest <input type="checkbox"/> Rotation Other positives: <input type="text"/> Other negatives: <input type="text"/>
Associated Symptoms/Pertinent Negatives:					
<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Bladder dysfunction not spinal related <input type="checkbox"/> Bladder incontinence <input type="checkbox"/> Bladder retention <input type="checkbox"/> Bowel dysfunction not spinal related <input type="checkbox"/> Bowel incontinence <input type="checkbox"/> Bowel retention	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Decreased mobility <input type="checkbox"/> Dermatomic rash <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Dysphagia <input type="checkbox"/> Incoordination <input type="checkbox"/> Joint pain	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Loss of balance <input type="checkbox"/> Muscle atrophy <input type="checkbox"/> Muscle spasm <input type="checkbox"/> Numbness <input type="checkbox"/> Rash <input type="checkbox"/> Sexual dysfunction	<input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Sexual dysfunction (not spinal related) <input type="checkbox"/> Tenderness <input type="checkbox"/> Tingling <input type="checkbox"/> Weakness <input type="checkbox"/> Weight loss	<input type="checkbox"/> No associated symptoms <input type="checkbox"/> No pertinent negatives <input type="checkbox"/> All others negative Other associated symptoms: <input type="text"/> Other pertinent negatives: <input type="text"/>	
Comments: <input type="checkbox"/> History of previous disc problem <input type="text"/> <input type="checkbox"/> History of spinal surgery <input type="text"/>					

Patient Name: _____

ARM/LEG PAIN

- Does your affected extremity change color: Yes No
- Does your affected extremity feel: warmer colder
- Does your affected extremity swell: Yes No
- Does light touch worsen your pain (putting on socks, sheets on the bed): Yes No
- Have you noticed hair nail growth on the affected extremity: Yes No

Please check all that apply.

Concern: musculoskeletal pain		Frequency: <input type="radio"/> Intermittent <input type="radio"/> Occasional <input type="radio"/> Constant <input type="radio"/> Rare	Status: <input type="radio"/> Changing <input type="radio"/> Fluctuating <input type="radio"/> Improving <input type="radio"/> Resolved <input type="radio"/> Stable <input type="radio"/> Worse
Onset: []	Severity: []		
Duration: []			
Location: <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral <input type="checkbox"/> Ankle <input type="checkbox"/> Hand <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Wrist <input type="checkbox"/> Foot Other: []	Radiation: <input type="checkbox"/> No <input type="checkbox"/> Yes Radiates to: []	Quality: <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Dull <input type="checkbox"/> Piercing <input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing Other: []	What caused onset of pain: <input type="checkbox"/> No injury <input type="checkbox"/> Injury <input type="checkbox"/> Sports injury: [] <input type="checkbox"/> MVA Details Other: []
Aggravated By: <input type="checkbox"/> Bending <input type="checkbox"/> Lifting <input type="checkbox"/> Nothing <input type="checkbox"/> Climbing stairs <input type="checkbox"/> Movement <input type="checkbox"/> Sitting <input type="checkbox"/> Descending stairs <input type="checkbox"/> Pushing <input type="checkbox"/> Standing Other: []		Relieved By: <input type="checkbox"/> Brace/splint <input type="checkbox"/> Ice <input type="checkbox"/> Mobility <input type="checkbox"/> Elevation <input type="checkbox"/> Injection <input type="checkbox"/> OTC medicines: [] <input type="checkbox"/> Exercise <input type="checkbox"/> Massage <input type="checkbox"/> Rest <input type="checkbox"/> Heat <input type="checkbox"/> Pain/RX meds <input type="checkbox"/> Stretching Other: []	
Associated Symptoms/Pertinent Negatives:			
<input type="checkbox"/> No associated symptoms Neg Pos <input type="radio"/> Bruising <input type="radio"/> Crepitus <input type="radio"/> Decreased mobility <input type="radio"/> Difficulty initiating sleep <input type="radio"/> Joint instability <input type="radio"/> Joint tenderness	<input type="checkbox"/> No pertinent negatives Neg Pos <input type="radio"/> Limping <input type="radio"/> Locking <input type="radio"/> Nocturnal awakening <input type="radio"/> Nocturnal pain <input type="radio"/> Numbness <input type="radio"/> Popping	<input type="checkbox"/> All others negative Neg Pos <input type="radio"/> Spasms <input type="radio"/> Swelling <input type="radio"/> Tingling in the arms <input type="radio"/> Tingling in the legs <input type="radio"/> Weakness	Other associated symptoms: [] Other pertinent negatives: [] ADLs Functional Limitations
Comments: []			
Hand dominance: <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Ambidextrous			

Patient Name: _____

HEADACHES

- Are there any signs that your headache is going to happen: Yes No

If Yes, what are the signs: _____

- How many hours do your headaches typically last? _____

Please check all that apply.

Headache Quick Visit		Severity of symptoms: <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> Incapacitating			
Concern: <input type="text" value="migraine"/>	Onset: <input type="text"/>	Status: <input type="radio"/> Improving <input type="radio"/> No change <input type="radio"/> Worse <input type="radio"/> Resolved			
Pain scale: <input type="text"/>		Frequency: <input type="radio"/> Constant <input type="radio"/> Recurring <input type="radio"/> Intermittent <input type="radio"/> Nocturnal			
Location:		Timing:		Context:	
<input type="checkbox"/> Entire head <input type="checkbox"/> Frontal <input type="radio"/> R <input type="radio"/> L <input type="radio"/> B <input type="checkbox"/> Vertex <input type="checkbox"/> Temporal <input type="radio"/> R <input type="radio"/> L <input type="radio"/> B <input type="checkbox"/> Occipital <input type="checkbox"/> Ocular <input type="radio"/> R <input type="radio"/> L <input type="radio"/> B <input type="checkbox"/> Neck <input type="checkbox"/> Parietal <input type="radio"/> R <input type="radio"/> L <input type="radio"/> B Other: <input type="text"/>		<input type="checkbox"/> Daytime <input type="checkbox"/> Upon waking <input type="checkbox"/> Menstrual cycle <input type="checkbox"/> Weekday <input type="checkbox"/> No pattern <input type="checkbox"/> Weekend <input type="checkbox"/> Nocturnal		N Y (what causes onset of pain) <input type="radio"/> Menses <input type="radio"/> Recent head trauma <input type="radio"/> Recent MVA <input type="radio"/> Stress Other negatives: <input type="text"/> Other positives: <input type="text"/> Comments: <input type="text"/>	
Aggravated by:		Relieved by:			
<input type="checkbox"/> Nothing N Y <input type="radio"/> Allergies <input type="radio"/> Certain foods <input type="radio"/> Anxiety <input type="radio"/> Exercise <input type="radio"/> Bright lights <input type="radio"/> Head position <input type="radio"/> Caffeine <input type="radio"/> Noise Other negatives: <input type="text"/> Other positives: <input type="text"/> Comments: <input type="text"/>		<input type="checkbox"/> Nothing N Y <input type="radio"/> Analgesics <input type="radio"/> Bath <input type="radio"/> Darkness <input type="radio"/> Decongestants <input type="radio"/> Heat <input type="checkbox"/> Ice <input type="radio"/> Massage <input type="radio"/> OTC meds <input type="radio"/> Prescription meds Other negatives: <input type="text"/> Other positives: <input type="text"/> Comments: <input type="text"/>			
Associated symptoms/Pertinent negatives: <input type="checkbox"/> No associated symptoms		<input type="checkbox"/> No pertinent negatives		<input type="checkbox"/> All others negative	
Neg Pos <input type="radio"/> Blurred vision <input type="radio"/> Diplopia <input type="radio"/> Dizziness <input type="radio"/> Fever <input type="radio"/> Hemianopsia left		Neg Pos <input type="radio"/> Hemianopsia right <input type="radio"/> Loss of consciousness <input type="radio"/> Memory loss <input type="radio"/> Nausea <input type="radio"/> Neck stiffness		Neg Pos <input type="radio"/> Personality changes <input type="radio"/> Phonophobia <input type="radio"/> Photophobia (sound) <input type="radio"/> Vision loss left (light) <input type="radio"/> Vision loss right	
Neg Pos <input type="radio"/> Visual aura <input type="radio"/> Vertigo <input type="radio"/> Vomiting				Other negatives: <input type="text"/> Other positives: <input type="text"/> Comments: <input type="text"/>	
Comments: <input type="text"/>					
Review of systems:				Office labs Office Diagnostics	
Constitutional Neg Pos Chills/rigors <input type="radio"/> Fatigue <input type="radio"/> Fever <input type="radio"/>		HEENT Neg Pos Visual loss left <input type="radio"/> Visual loss right <input type="radio"/>		<input type="checkbox"/> CBC Diagnosis: <input type="text"/> Code: <input type="text"/>	
HEENT Neg Pos Headache <input type="radio"/> Diplopia <input type="radio"/> Photophobia <input type="radio"/> Vertigo <input type="radio"/>		Gastrointestinal Neg Pos Nausea <input type="radio"/> Vomiting <input type="radio"/>			
		Musculoskeletal Neg Pos Neck stiffness <input type="radio"/>		Immunological Neg Pos Environmental allergies <input type="radio"/>	
				(Labs ordered here will not upload to lab module)	
				<input type="button" value="Place Order"/> <input type="button" value="OK"/> <input type="button" value="Cancel"/>	

Patient Name: _____

(0 = No pain / 10 = Pain as bad as you can imagine)

PAIN LEVELS:

Current Pain Level: Least Pain Level: Worst Pain Level: Pain Goal:

IS PATIENT TAKING:

Blood Thinners?

Who Manages Blood Thinners?

Supplements?

Antibiotics?

DOES PATIENT HAVE:

Allergy to Contrast Dye, Latex, or Shellfish?

Liver Problems? (Hep C)

Diabetes?

MEDICATIONS-

Please list ALL medications, including herbal and over-the-counter:

Drug	Dose	Prescribing Provider

ALLERGIES-

Drug/Item	Reaction

Patient Name: _____

REVIEW OF SYSTEMS-

Please mark all current or chronic conditions:

Constitutional

- Chills
- Fatigue
- Fever
- Malaise (out of sorts)
- Night sweats
- Weight gain
- Weight loss
- Other: _____

HEENT

- Ear discharge
- Ear pain
- Eye discharge
- Eye pain
- Hearing loss
- Nasal discharge
- Sinus pressure
- Sore throat
- Visual changes
- Other: _____

Respiratory

- Chronic cough
- Cough
- Known TB exposure
- Shortness of breath
- Wheezing
- Other: _____

Cardiovascular

- Chest pain
- Claudication (leg cramping)
- Edema (swelling)
- Palpitations
- Other: _____

Gastrointestinal

- Abdominal pain
- Blood in stools
- Change in stools
- Constipation
- Diarrhea
- Heartburn
- Loss of appetite
- Nausea
- Vomiting
- Other: _____

Genitourinary-FEMALE

- Dysuria (painful urination)
- Hematuria (bloody urine)
- Polyuria (excessive urination)
- Urinary frequency
- Urinary incontinence
- Urinary retention
- Other: _____

Reproductive-FEMALE

- Abnormal Pap
- Dysmenorrhea (painful periods)
- Dyspareunia (painful intercourse)
- Hot flashes
- Irregular menses
- Vaginal discharge
- Other: _____

Genitourinary-MALE

- Dribbling
- Dysuria (painful urination)
- Hematuria (bloody urine)
- Polyuria (excessive urination)
- Slow stream
- Urinary frequency
- Urinary incontinence
- Urinary retention
- Other: _____

Reproductive-MALE

- Erectile dysfunction
- Penile discharge
- Sexual dysfunction
- Other: _____

Integumentary

- Breast discharge
- Breast lump
- Brittle hair
- Brittle nails
- Hair loss
- Hirsutism (male pattern hair in women)
- Hives
- Pruritis (itching)
- Mole changes
- Rash
- Skin lesion
- Other: _____

Neurological

- Dizziness
- Extremity numbness
- Extremity weakness
- Gait disturbance
- Headache
- Memory loss
- Seizures
- Tremors
- Other: _____

Psychiatric

- Anxiety
- Depression
- Insomnia
- Other: _____

Metabolic/Endocrine

- Cold intolerance
- Heat intolerance
- Polydipsia (excessive thirst)
- Polyphagia (excessive hunger)
- Other: _____

Musculoskeletal

- Back pain
- Joint pain
- Joint swelling
- Muscle weakness
- Neck pain
- Other: _____

Hematologic/Lymphatic

- Easy bleeding
- Easy bruising
- Lymphadenopathy (enlarged lymph nodes)
- Other: _____

Immunologic

- Contact allergy
- Environmental allergies
- Food allergies
- Seasonal allergies
- Other: _____

Patient Name: _____

PREVIOUS SURGERIES-

Please be as specific as possible:

Surgery	Date	Location/Physician

MEDICAL HISTORY-

Please be as specific as possible:

Condition	Management	Treatment Outcome

FAMILY HISTORY-

- Is your mother living: Yes No
 If Yes, Age: _____ If No, Age at death: _____
 List all medical problems: _____

- Is your father living: Yes No
 If Yes, Age: _____ If No, Age at death: _____
 List all medical problems: _____

- Siblings:
 - Brother Sister Living: Yes No
 If Yes, Age: _____ If No, Age at death: _____
 List all medical problems: _____

 - Brother Sister Living: Yes No
 If Yes, Age: _____ If No, Age at death: _____
 List all medical problems: _____

 - Brother Sister Living: Yes No
 If Yes, Age: _____ If No, Age at death: _____
 List all medical problems: _____

Patient Name: _____

SOCIAL-

- Have you had any recent social changes (marriage, divorce, employment, etc.): Yes No
If Yes, describe: _____
- Are you married: Yes No
If Yes, How Long: _____ Name of spouse: _____
- Is your spouse deceased: Yes No If Yes, When: _____ / _____ / _____
- Have you been divorced: Yes No If Yes, How many times: _____
- Are you currently employed: Yes No If Yes, How long: _____
Occupation: _____
- Are you receiving disability: Yes No
- Is this pain being treated by a workers compensation claim: Yes No
- Have you taken any legal action in regards to your pain: Yes No
- Have you ever been abused: Yes No If Yes, Physical Sexual Emotional

HABITS-

- Do you smoke: Yes No Quit When: _____ / _____ / _____
If Yes, Packs per day: _____ Years: _____
- Do you smoke a pipe: Yes No Quit When: _____ / _____ / _____
If Yes, How much: _____ Years: _____
- Do you chew tobacco: Yes No Quit When: _____ / _____ / _____
If Yes, How much: _____ Years: _____
- Do you drink alcohol: Yes No Quit When: _____ / _____ / _____
If Yes, How much: _____ Years: _____
- Do you use illegal drugs: Yes No Quit When: _____ / _____ / _____
If Yes, How much: _____ Years: _____
What types: _____
- Do you consume caffeine: Yes No
If Yes,
 - Coffee _____ cups/day
 - Tea _____ cups/day
 - Soda _____ cups/day
 - Energy Drinks _____ cups/day