ABOUT YOUR PAIN

Where is your pain located? _____

How long have you had this pain? _____

What started your pain? _____

Circle those that apply to the pain you are feeling:

*Burning Stabbing Throbbing Aching Electrical Other*_____

Is the pain: Constant Intermittent

Does the pain radiate? ( ) Yes ( ) No Where? _____

Is there anything you can do to help relieve the pain? _____

_____

What makes the pain worse? _____

Is this injury as a result of an auto accident? ( ) Yes ( )No Date of Injury: _____

If it was an auto accident, were you the: ( ) Driver ( ) Passenger

Were you wearing a seat belt? ( ) Yes ( ) No

Have you had any x-rays, MRI scans, CT scans, CT myelogram or bone scans? If so, where? _____

_____

Have you had any physical therapy? If so, where? _____

_____

Have you had any injections or procedures? If so, what and by whom? _____

_____

Have you had any surgeries related to this injury? If so, what and by whom? _____

_____

Have you had electrodiagnostic studies (EMG) or nerve conduction studies (NCS)? If so, by whom and when?

_____

_____

Current Medications: _____

_____

_____

Are you allergic to any medications? If so, please list them: ( ) Yes ( ) No

_____

PAST MEDICAL HISTORY

List past and present medical problems (Example: diabetes and hypertension):

_____

_____

_____

_____

List any past surgeries (include those not pertaining to this injury):

_____

_____

_____

Are you taking any blood thinning medication (such as Coumadin)? _____

List other physicians you are seeing: _____

_____

SOCIAL HISTORY

Are you currently employed? ( ) No ( ) Yes, If so, Where? _____

Job Requirements:

___*Lifting*____*lbs* ___*Squatting* ___*Bending*

___*Pushing* ___*Sitting* ___*Pulling*

___*Standing* ___*Other*

Hobbies: _____

Are you married? *Yes* *No*

Do you have children? *Yes* *No* *If so, how many?* _____

Do you smoke? *Yes* *No* *If so, how many?* _____

Do you drink alcohol? *Yes* *No* *If so, how often?* _____

Do you use illicit drugs? *Yes* *No* *If so, what kind and how often?* _____

Do you have a history of prescription drug abuse? *Yes* *No* *If so, please explain:* _____

_____

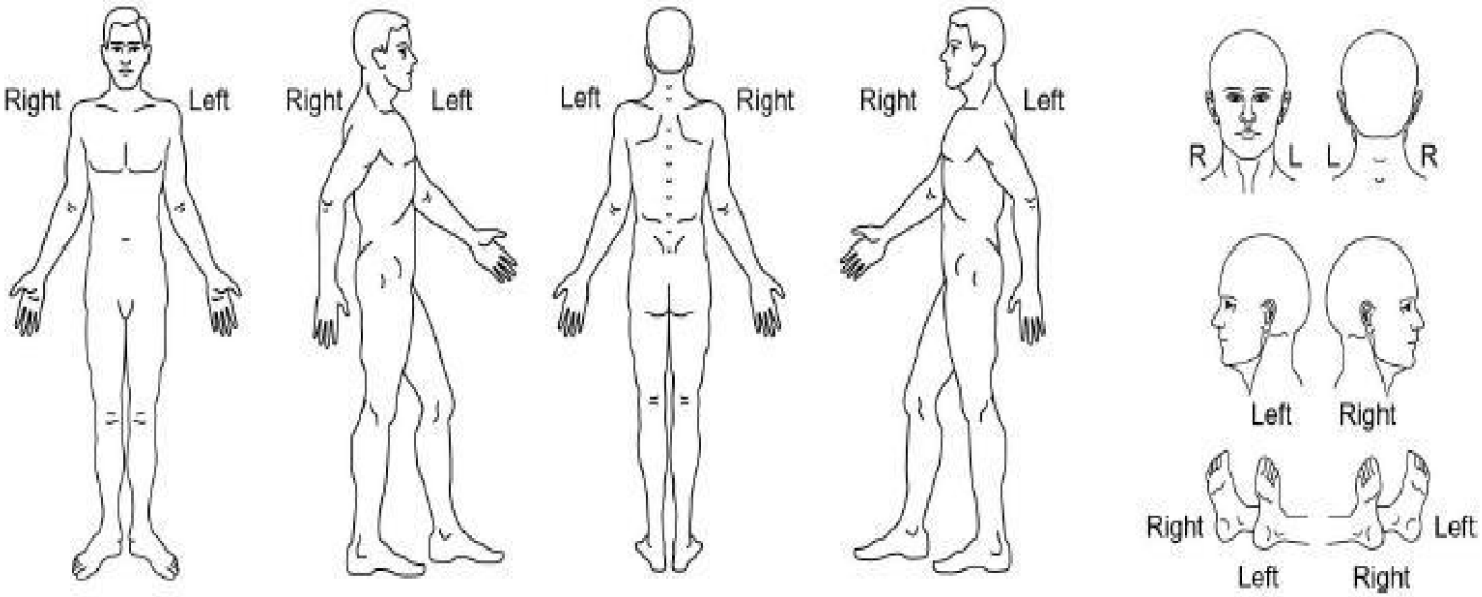
Describe Your Pain

1*. Draw on the figure below indicating where your pain starts. Mark it with an X and show where the pain radiates with an arrow. If the pain covers a large area, shade the area. Circle the words that best describes your pain.*

CONSTANT *INTERMITTENT* *THROBBING* *SHOOTING* *STABBING*

SHARP *CRAMPING* *BURNING* *TINGLING* *STINGING* *SPASMS*

DULL *RADIATING* *SQUEEZING* *PINS & NEEDLES* *TIGHTNESS*



2. Please circle one word that describes your present pain from the following:

No pain **Mild** **Discomfort** **Horrible** **Excruciating**

3. How many hours per day do you spend sleeping? _____ Lying down with your feet off the floor? _____

4. Indicate how well you are coping with your pain:
   (**well**) 0 1 2 3 4 5 6 7 8 9 10 (**Poorly**)
5. Indicate the level of functional limitations:
   (**unlimited)** 0 1 2 3 4 5 6 7 8 9 10 (**limited**)
6. Indicate your average pain level during the last 2 weeks:
   (no pain) 0 1 2 3 4 5 6 7 8 9 10 **(severe)**