CVPM | CENTRAL VALLEY PAIN MANAGEMENT

Patient Conservative Treatment History

Patient Name: _____ DOB: _____Date: _____

All patients must fill out this form. Insurance will not pay for your procedures or prescriptions without this information.

1. Have you had physical therapy? YES NO How long ago? _____

How many times did you go? _____

Did it help your pain? _____

How long did it help? _____

2. Have you had chiropractic treatment? YES NO How long ago? _____

How many times did you go? _____

Did it help your pain? _____

How long did it help? _____

3. What medications have you tried to manage your pain?

_____

_____

Did they help with your pain? _____

How much did they help? (%)_____

What are your current medications and how much do they help with your pain?

_____

_____

4. Have you tried any other conservative treatment?

Acupuncture: _____ TENS UNIT: _____

Pool Therapy: _____ Other: _____

Did any of these help?_____

5. Have you had moderate to severe pain for at least 3 months that is affecting your activities of daily living?_____

What activities does it affect?

_____

6. Do you exercise at home? YES NO

What exercise do you do?

_____