PAIN REHABILITATION ASSOCIATES

PERSONAL MEDICAL HISTORY

DATE:	DATE OF BIRTH:
NAME:	
Referred By:	
Marital Status: ___M ___S ___D ___W	AGE:
Are you suing because of your pain? ___Yes ___No	
Attorney Name:	Atty Phone No:

CHIEF COMPLAINT:
How can we help you? What concerns do you want us to address today? Where is your pain?

HISTORY OF PRESENT ILLNESS (HPI):
When did these problems start?

Did you have problems with these concerns before that? ___Yes ___No
If yes, list what problems you did have and list the treatment received:

Explain how these problems began:______________________________ Date:______________

Describe How Injury Occurred-In Detail:

___Motor vehicle accident ___Seat belted
___Driver ___Unrestrained
___Passenger (front/back) ___At work
Further explain:

List medical care received since that time and the doctors who prescribed treatments:
(Also list tests you have had done, i.e. blood work, MRI, CAT scan, EMG, x-rays, etc.)
Are your symptoms better or worse than when they first started? ____Better ____Worse ____No Change

Describe exactly where and what type of pain you are experiencing using the examples below (location, duration, intensity of pain 0-10: Examples: *stabbing, aching, throbbing, shooting*

Does anything make the pain better or worse?

Do you notice any of the following in your ARMS or LEGS?

____pain ____weakness ____pins/needles sensation ____numbness ____tingling ____Other

Do any of these make your symptoms feel worse? Please note what area of your body this affects

____coughing
____sneezing
____sitting
____standing
____lying down
____walking
____physical activity
____sexual activity

Do you have any of these symptoms? If so, please specify area affected:

____muscle spasms____
____bowel or bladder problems ________________________________
____other____

Do you have any of these associated problems:

____change in your vision
____change in your balance
____blackouts or fainting spells
____seizures or fits
____headaches
____getting lost while driving
____difficulty concentrating
____memory problems
____other

How has this problem affected your life? What does it prevent you from doing?:

Has this problem kept you from being able to perform your job?

Has this problem affected your ability to sleep? ____Yes ____No

Does this affect your mood? ____Yes ____No
If yes, how?
____depression
____irritability
____anxiety
____other____

Do you have any associated jaw problems? ____Yes ____No

PAST MEDICAL HISTORY

Do you have ☐ Diabetes, ☐ High Blood pressure, ☐ Other

Have you had any surgery? ____Yes ____No
If yes:
Type of surgery:____Approximate Date_______________

Type of surgery:____Approximate Date_______________

Type of surgery:____Approximate Date_______________

Type of surgery:____Approximate Date_______________

Are you right-handed or left handed? ____right ____left

Describe other medical problem you are currently or have been treated for, and the name of your doctor(s):

MEDICATIONS:
List MEDICATIONS and DOCTORS WHO PRESCRIBE THEM: (please also list present medications)

Are you allergic to any medications? ____Yes ____No
If yes, what is the medication and what is the allergic reaction to it?

FAMILY HISTORY:
Do any medical conditions run in your family?

SOCIAL HISTORY:
What is your current occupation and name of company: ____

____

How many hours per week do you work?____
Do you have any children? (please list names and ages)

What is your educational background?

____high school ____college ____technical ____graduate school

How much alcohol do you consume in a week?____

Do you smoke? ____Yes ____No If yes, how much? ____

REVIEW OF SYSTEMS:
Is there anything else you would like the doctor to address at this visit?

PAIN DIAGRAM

NAME:________________________

DATE OF BIRTH:______________

TODAY'S DATE:______________

Please indicate where your pain is on this diagram by marking the area(s) with the symbols below:

Minimal to Moderate Pain

Severe Pain

↓ Shooting Pain

Numbness or Tingling

Pain Guide
(No pain at all=0 Moderate=5 Very severe=10)

- Please rate your pain by circling one number that best describes your pain right now, at this moment.
  0 1 2 3 4 5 6 7 8 9 10

- Rate your pain at its worst in the last week.
  0 1 2 3 4 5 6 7 8 9 10

- Rate your pain at its least in the last week.
  0 1 2 3 4 5 6 7 8 9 10

- Rate your pain on the average.
  0 1 2 3 4 5 6 7 8 9 10

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Reviewed By