

PAIN REHABILITATION ASSOCIATES

PERSONAL MEDICAL HISTORY

| | |
|---|----------------|
| DATE: | DATE OF BIRTH: |
| NAME: | |
| Referred By: | |
| Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W | AGE: |
| Are you suing because of your pain? <input type="checkbox"/> Yes <input type="checkbox"/> 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 lying down
 sneezing walking
 sitting physical activity
 standing 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 getting lost while driving
 change in your balance difficulty concentrating
 blackouts or fainting spells memory problems
 seizures or fits other
 headaches

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: _____

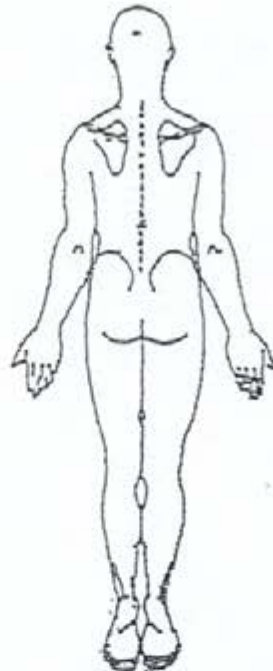
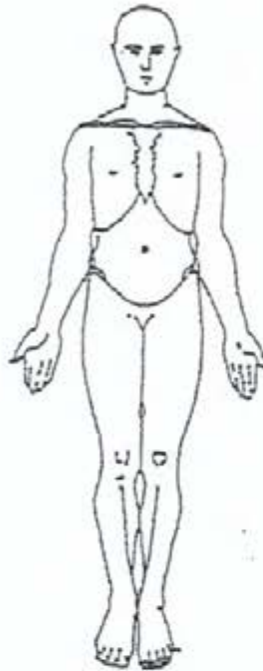
Please indicate where your pain is on this diagram by marking the area(s) with the symbols below:

 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

Reviewed By _____