Pacific Coast Spine Institute and Pain Center

Patient Name:_____ Date:_____

1. Where is your pain? O head O neck O right arm O left arm O right shoulder
   O left shoulder O low back O right hip O left hip O left knee O right knee O right buttock
   O left buttock O right foot O left foot O Abdomen O Pelvic

2. What do you believe to be the cause of your pain? O Fall O heavy lifting O trauma
   O accident O job injury

3. Check all the words that describe your pain: O constant O episodic O electric O sharp
   O burning O achy O dull O throbbing O shooting O numbness O tingling
   O hot O cold

4. What is the duration of your pain? O less than 6 months O more than 6 months O more than 1 year
   O more than 5 years O more than 10 years

5. Overall your pain is? O mild O moderate O severe

6. When is your pain worse? O morning O midday O afternoon O night O all the time

7. What activities make your pain worse? O coughing O sneezing O sitting O driving O walking
   O standing O lying down O bending

8. What activities make your pain better? O walking O standing O sitting O lying down O heat
   O ice O medication O nothing

9. To treat the pain you have tried: O Over the counter medication O prescription medication
   O chiropractor treatment O physical therapy O heat O ice O psychotherapy/behavioral therapy
   O acupuncture O traction O TENS O massage therapy O nerve blocks O epidural injections
   O none of the above

10. To evaluate your pain, you have had: O X-ray O MRI O CT scan O myelography
    O nerve conduction study O bone scan O none of the above

Past Medical History

Hypertension	O Yes	O No
Heart Disease	O Yes	O No
Diabetes	O Yes	O No
Lung Disease	O Yes	O No
Asthma	O Yes	O No
Stroke	O Yes	O No
Liver Disease	O Yes	O No
Kidney Disease	O Yes	O No
Gastritis	O Yes	O No
GERD	O Yes	O No

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Psychiatric Disorder	O Yes	O No
Depression	O Yes	O No
Substance Abuse	O Yes	O No
Alcohol Abuse	O Yes	O No

Family History

Has anyone in your family been diagnosed with any of the following? O diabetes O hypertension O chronic painO depression O substance abuse O alcohol abuse O psychiatric disorder O arthritis O none

Social History

Marital Status O Married O Divorced O Single O Widowed O Life partner

Do you have children? O Yes O No

Do you have family issues? O Yes O No

What is your alcohol consumption O never O occasionally O regularly

Do you smoke? O never O occasionally O regularly

Do you use illicit drugs? O never O occasionally O regularly

What is your job status? O full time O part time O student O retired O not working due to pain O disabled

Are you involved in a litigation (lawsuit)? O Yes O No

Review of Systems

<u>Constitutional</u>		
Weight Gain	O Yes	O No
Loss Of Appetite	O Yes	O No
Fever	O Yes	O No
Weakness	O Yes	O No
Weight Loss	O Yes	O No
Fatigue	O Yes	O No
Insomnia	O Yes	O No
<u>Urology</u>		
Urinary Incontinence	O Yes	O No
Frequent Urination	O Yes	O No
Difficulty Urinating	O Yes	O No

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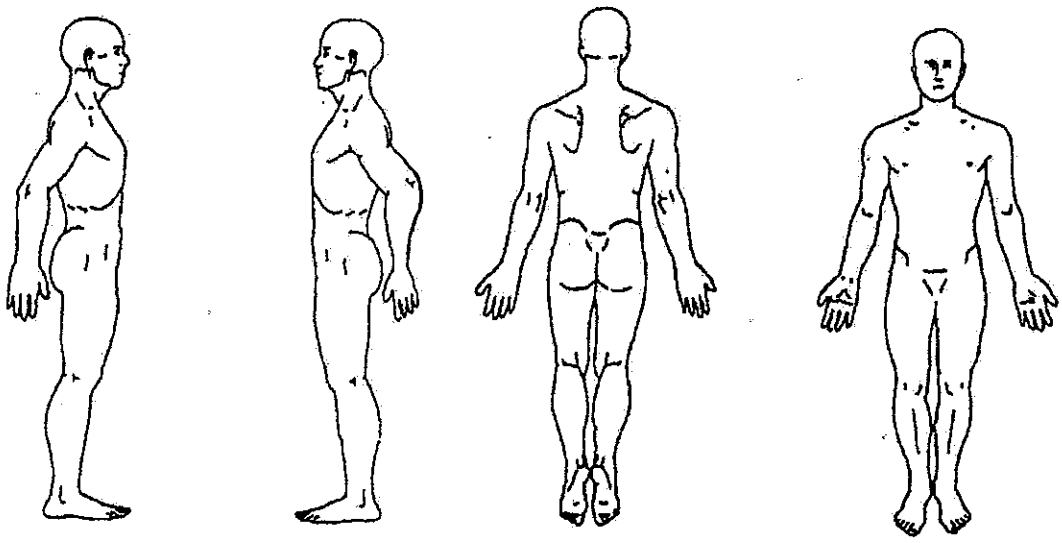
ENT		
Hearing Difficulty	O Yes	O No
Cardiology		
Dizziness	O Yes	O No
Chest Pain (Angina)	O Yes	O No
Irregular Heartbeats (Palpitations)	O Yes	O No
Leg Edema	O Yes	O No
Shortness Of Breath	O Yes	O No
Cold Extremities	O Yes	O No
Palpitations	O Yes	O No
Gastroenterology		
Blood In Stool	O Yes	O No
Diarrhea	O Yes	O No
Vomiting	O Yes	O No
Constipation	O Yes	O No
Nausea	O Yes	O No
Heartburn	O Yes	O No
Neurology		
Memory Loss	O Yes	O No
Tremors	O Yes	O No
Loss Of Balance	O Yes	O No
Ophthalmology		
Blurring Of Vision	O Yes	O No
Respiratory		
Shortness Of Breath	O Yes	O No
Wheezing	O Yes	O No
Cough	O Yes	O No
Hematology/Lymph		
Abnormal Bruising	O Yes	O No
Abnormal Bleeding	O Yes	O No
Varicose Veins	O Yes	O No
HEENT		
Change In Vision	O Yes	O No
Double Vision	O Yes	O No

Patient Name:_____ Date:_____

1) Where is your pain? Circle all that apply:



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Medications and Allergies

Medications

O None

Please list current medications taken with dosage and frequency:

Drug	Strength	Frequency
Over the Counter Meds:		

Allergies

O No Known Drug Allergies

Please list any known drug allergies including the reaction:

Name of Drug	Allergic Reaction

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Surgeries

Please list all surgeries:

Date of Surgery	Surgery