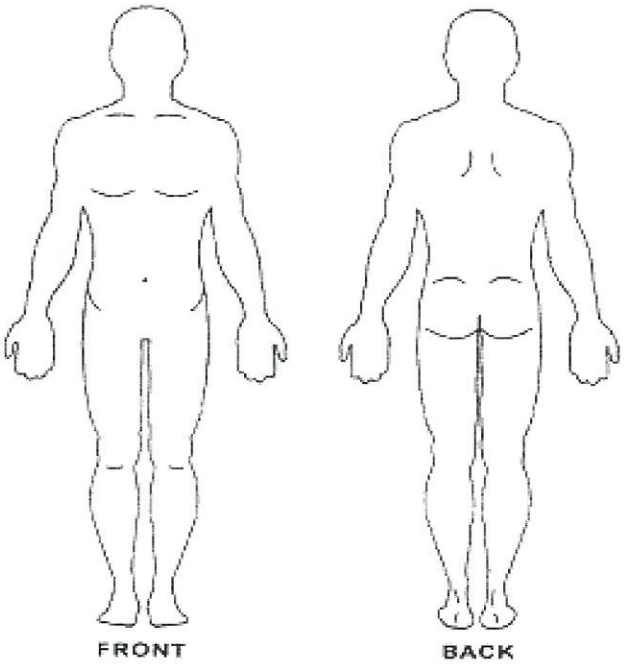
SUMMIT MEDICAL CENTER
Pain Clinic

Patient Name: _____ **Date:** _____ **DOB:** ___/___/_____

Mark the area on your body where you feel the described sensations.

Numbness - - - - - Pins & Needles 0 0 0 0 0

Burning X X X X X Stabbing / / / / / Ache * * * * *



How does your pain respond to the following activities?

	Worse	Better
Walking	☐	☐
Standing	☐	☐
Sitting	☐	☐
Lying Down	☐	☐
Bending	☐	☐
Bowel Movement	☐	☐
Driving	☐	☐
Coughing/Sneezing	☐	☐
Rising from Sitting	☐	☐
Home Remedy	☐	☐

Visual Analog Scale

Please indicate on the scale below your level of pain with 10 being the worst.

Use an "X" to indicate your most severe pain

Use an "O" to indicate your average amount of pain.

None 0 1 2 3 4 5 6 7 8 9 10 Worst

Please answer each of the following questions:

Pain in arm(s) / leg(s) compared to neck / back: ☐ More than ☐ Same as ☐ Less than

Is there weakness of your arms / legs? ☐ Yes ☐ No

How long can you sit with no/minimal pain? _____ How long can you stand with no/minimal pain? _____

How far can you walk with no/minimal pain? _____

Have you had trouble controlling your bowels and bladder? ☐ Yes ☐ No If yes, is this a new problem? _____

Patient Signature: _____ **Date:** _____

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Name: _____ Today's Date: ___/___/_____ Age: ____ DOB: ___/___/_____

SECTION 1 Current Chief Complaint

Chief Complaint: _____

_____

When did your pain start? ___/ ___/ _____ Date of Injury: ___/ ___/ _____ How did symptoms start? _____

_____

_____

Pain began: ☐ Suddenly ☐ Gradually ☐ Chronic Related to: ☐ Job ☐ Accident ☐ Unsure

SECTION 2 Current Medical History:

Height: ____ft. ____in. Weight: _____ lbs. If female, are you pregnant? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Are you claustrophobic? ☐ Yes ☐ No

Have you ever been diagnosed or treated for the following: (If you check a box, please explain)

- ☐ Diabetes _____
- ☐ High blood pressure _____
- ☐ Thyroid disease or disorder _____
- ☐ Cancer, tumor, or leukemia (type/location) _____
- ☐ Eye conditions, glaucoma, or cataracts _____
- ☐ Ear, nose, mouth or throat disorder _____
- ☐ Chest pain, murmur, heart, or blood vessel disorder _____
- ☐ Asthma, tuberculosis, or other lung disease _____
- ☐ Liver, intestinal, or gallbladder disorder _____
- ☐ Kidney, bladder, or urinary tract disorder _____
- ☐ Sexually transmitted disease (i.e. syphilis, gonorrhea) _____
- ☐ Skin disorder, rash, or itching _____
- ☐ Mental disorders, anxiety, depression, or seizures _____
- ☐ AIDS or HIV positive test results _____
- ☐ Staph infection _____
- ☐ Drug or alcohol dependency _____
- ☐ COPD ☐ Sleep apnea _____
- ☐ Arthritis ☐ Gout _____
- ☐ Stroke ☐ Heart attack _____

Other medical problems:

Family History:

- ☐ Diabetes ☐ Heart disease
- ☐ Stroke ☐ Kidney disease
- ☐ Arthritis/Gout ☐ Cancer
- ☐ Mental illness ☐ Sickle cell
- ☐ Bleeding issues ☐ Hypertension

Anesthesia History:

- ☐ Any anesthesia problems other than nausea and vomiting
- ☐ Difficulty opening your mouth
- ☐ Family history of malignant hyperthermia
- ☐ History or prolonged weakness after anesthesia

SECTION 3 Current Physician and Previous Care

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

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Name: _____ DOB: ___/___/_____ Today's Date: ___/___/_____

Social History

Education: ☐ Some High School ☐ 4-Year Collage Degree
☐ High School Diploma/GED ☐ Master Degree
☐ Some College ☐ Professional Degree
☐ 2-Year College Degree

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Smoking History: ☐ Never ☐ Quit ☐ Currently Smoke _____ Pack(s) each day For how long? _____

Alcohol Use: ☐ Never ☐ Occasional ☐ Daily ☐ For how long? _____

Illicit Drug Use: ☐ Never ☐ Occasional ☐ Daily ☐ For how long? _____

Exercise: ☐ Sedentary ☐ Active but no formal exercise ☐ Regular exercise _____ Days per week

With which hand do you write? ☐ Left ☐ Right

Occupation: **Employer:**

Review Systems

Please Check all (☐) positive symptoms and describe or add others, if needed

Constitutional: ☐ Fever ☐Weight gain/loss ☐Loss of appetite

Eyes: ☐Double Vision, ☐Blurring, ☐ Difficulty seeing

ENT: ☐Deafness, ☐Hoarseness, ☐ Vertigo ☐Sinusitis

Cardiovascular: ☐ Chest Pain, ☐Palpitations, ☐Murmur, ☐Irregular/rapid heart beat

Respiratory: ☐ Chronic cough, ☐Spitting blood, ☐Wheezing, ☐Shortness of breath

Digestive: ☐Abdominal pain, ☐Constipation, ☐Diarrhea, ☐Bleeding

Skin: ☐ Lesions that don't heal, ☐Changes in moles, ☐Rashes

Gynecologic: ☐Missed periods, ☐Pain when urinating, ☐ Bleeding, ☐Hesitancy, Incontinence

Psychiatric: ☐Depression, ☐Anxiety, ☐Hallucinations, ☐ Sleep disturbances

Endocrine: ☐Excessive thirst, ☐Excessive urination, ☐heat/cold intolerance

Blood and Lymph: ☐Anemia, ☐Bleeding tendencies ☐Swollen Nodes

Allergic and Immunologic: ☐Hives ☐ Eczema, ☐ Itching

Musculoskeletal: ☐ Stiffness, ☐Joint Pain/Deformity. ☐Muscle wasting, ☐Spine ☐Pain radiating to arms/legs

Neurologic: ☐ Seizures, ☐Loss of balance/coordination, ☐Paralysis, ☐Loss of memory, ☐Weakness, ☐ Numbness, ☐Loss of sensation in arms/legs, ☐Tingling, Facial Pain

Past Surgeries

Please List all previous surgeries. **Include the date and physician.** ☐ I have **never** had surgery

_____

_____

_____

_____

_____

_____

_____

_____

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Name: _____ DOB: ___/___/_____ Today's Date: ___/___/_____

Pervious Testing: What previous diagnostic tests have you had for your symptoms?

Please include when and where the test was performed

None ☐

X-Ray: _____

MRI: _____

CAT Scan: _____

Myelogram: _____

Discogram: _____

Bone Scan: _____

Electrical Nerve Testing: _____

Pervious Care: Where, in the past, have you sought help for your symptoms?

None ☐

Neurosurgeon: _____

Orthopedic Surgeon: _____

Neurologist: _____

Primary Care Provider: _____

Rheumatologist: _____

Physiatrist: _____

Acupuncturist: _____

Chiropractor: _____

Emergency Room: _____

Pain Clinic: _____

Other: _____

Pervious Treatments: What treatments have you had for your symptoms?

Please include when and where the treatment was performed?

None ☐

Surgery: _____ ☐ Yes ☐ No

Epidural Steroids: _____ ☐ Yes ☐ No

Physical Therapy: _____ ☐ Yes ☐ No

Other: ☐ Yes ☐ No

Current Medications: Please include prescribing physician and dosage.

_____ | _____

_____ | _____

_____ | _____

_____ | _____

Pharmacy Name and Number: _____

May we have consent to access your medication history? ☐ Yes ☐ No

Allergies

☐ I have no know allergies

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to Shellfish? ☐ Yes ☐ No

Are you allergic to any type of tape ☐ Yes ☐ No If yes, what type? _____

Are you allergic to any Medications? _____

Are you allergic to CT Contrast Dye/Gadolinium? ☐ Yes ☐ No

Are you allergic to any type of Food? _____

Other? _____