PAIN DRAWING

PATIENT: ______________________ **AGE:**________ **DATE:** ______________

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas. Just to complete the picture, please draw in your face.

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	RADIATING PAIN
^ ^ ^	O O O	■ ■ ■	X X X	/ / /
^ ^ ^	O O O	■ ■ ■	X X X	/ / /
^ ^ ^	O O O	■ ■ ■	X X X	/ / /

Neck Pain _______%
Arm Pain _______%
Back Pain _______%
Leg Pain _______%

Total = 100%

RIGHT LEFT LEFT RIGHT

PLEASE MARK ON THE LINE:

How bad is your pain now?

❶____❷____❸____❹____❺____❻____❼____❽____❾____❿

NO PAIN **INTERMEDIATE PAIN** **WORST PAIN**

Is your problem related to:
- ☐ Job Injury
- ☐ Car Accident
- ☐ Other ___________

Is there any litigation pending?
- ☐ No
- ☐ Yes, please describe ________________________________

____

Please briefly describe your main problem:

____

____

How has this interfered with your life?

____

____

How long has this been a problem? ____

What makes the pain better ☐ Sitting ☐ Standing ☐ Other _________________________
How long can you stand with minimal or no pain? ____
How far can you walk with minimal or no pain? ____
How long can you sit with minimal or no pain? ____
What makes the pain worse? ____
How does coughing or sneezing affect the pain? Worse Better No Difference

Have you ever had any problems like this in the past or required hospitalization for this problem?
☐YES ☐NO
If YES, describe____

____

Have you seen any other doctors for this problem or had surgery?
Dr. ________ Specialty _________ Date ______ Recommendation: ______________________
Dr. ________ Specialty _________ Date ______ Recommendation: ______________________

Describe your treatment(s) to date (including injections, chiropractor/alternative treatments)

____

____

Which diagnostic tests were performed?

	Test	Date	Results
☐	Xrays	Date ______	Results ______________________________
☐	CT scan	Date ______	Results ______________________________
☐	MRI	Date ______	Results ______________________________
☐	EMG	Date ______	Results ______________________________
☐	Discogram	Date ______	Results ______________________________
☐	Myelogram	Date ______	Results ______________________________
☐	Dexa Scan	Date ______	Results ______________________________

For office use only:

____

____

____

____

MEDICAL HISTORY

Primary care physician _________________Contact info ______________________________

Please check below any condition that applies and add any comments that apply.

	YES	NO	Comments		YES	NO	Comments
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Bleeding Disorder				Immune Disorder			
Bowel Disorder				Kidney Disorder			
Cancer				Liver Disease			
Depression				Rheumatoid Arthritis			
Diabetes				Stroke			
Drug/Alcohol Abuse				Thyroid Disease			
Epilepsy				Tuberculosis			
Heart Disease				Ulcers			
Other (describe):							

Previous Hospitalizations, major surgeries, serious infections and approximate dates
____
____
____
____

SOCIAL HISTORY

Occupation _____________ Marital Status _________ Highest education level __________
Work Status: ☐Full Duty ☐Light Duty ☐Off Duty (per M.D.) ☐Unemployed ☐Retired
If you are not working full duty, how long have you been off work? _________________

Tobacco YES NO
Cigarettes Pack(s) per day _____ How many years ___ If you quit, when? _______
Other tobacco Amount per day _____ How many years ___ If you quit, when? _______

Alcohol YES NO
If yes, how often and how much ____
Have you ever received formal treatment for dependency _____________________________

Do you currently or have you ever used any recreational drugs? ☐ YES ☐ NO
If yes, please list all and how often ____

FAMILY HISTORY

Please list health problems in your family:

	Age	Medical Problems	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			
Grandparents			

SYSTEM REVIEW

Constitutional
- Recent weight changes ☐Yes ☐No
- Recurrent fevers/chills ☐Yes ☐No

Eyes, Ear, Nose, Throat
- Changes in vision ☐Yes ☐No
- Glaucoma ☐Yes ☐No
- Difficulty Hearing ☐Yes ☐No
- Dizziness ☐Yes ☐No

Respiratory
- Breathing problems ☐Yes ☐No
- Coughing blood ☐Yes ☐No
- Pneumonia ☐Yes ☐No
- Asthma or wheezing ☐Yes ☐No

Cardiovascular
- Chest pain ☐Yes ☐No
- Palpitations ☐Yes ☐No
- Difficulty exercising ☐Yes ☐No
- Swelling of feet/hands ☐Yes ☐No
- Blood clots ☐Yes ☐No

Gastrointestinal
- Nausea ☐Yes ☐No
- Vomiting ☐Yes ☐No
- Bleeding ulcers ☐Yes ☐No
- Diarrhea ☐Yes ☐No
- Bloody stools ☐Yes ☐No
- Abdominal pain ☐Yes ☐No
- Ulcers ☐Yes ☐No

GenitoUrinary
- Bloody urine ☐Yes ☐No
- Burning with urination ☐Yes ☐No
- Unable to control bowel ☐Yes ☐No
- Unable to control bladder ☐Yes ☐No
- Abnormal periods (women) ☐Yes ☐No

Neurological
- Numbness/tingling ☐Yes ☐No
- Weakness ☐Yes ☐No
- Seizures ☐Yes ☐No
- Crying problems ☐Yes ☐No
- Depression ☐Yes ☐No

Skin
- Rashes ☐Yes ☐No
- Non-healing wounds ☐Yes ☐No
- Skin infections ☐Yes ☐No
- Easy bruising/bleeding ☐Yes ☐No

Musculoskeletal
- Joint pain/swelling ☐Yes ☐No
- Muscle pain/cramping ☐Yes ☐No
- Difficulty walking ☐Yes ☐No

Endocrine
- Excess thirst/urination ☐Yes ☐No
- Thyroid problems ☐Yes ☐No

Allergic
- Recent cold/flu ☐Yes ☐No
- Hay/dust fever ☐Yes ☐No

I have personally reviewed and discussed all the preceding information with my patients.

Physician Signature ______________________________________ Date ____________

MEDICATIONS FORM

List all medications – please include dosages and frequency

Medications	Medications
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Medication		Helpful?	Medication		Helpful?	Medication		Helpful?
Aspirin			Glucosamine			Prozac		
Bextra			Ibuprofen			Relafen		
Celebrex			Lortab			Skelaxin		
Darvocet			Mobic			Soma		
Demerol			Motrin			Tylenol		
Dilaudid			Naprosyn			Tylenol #3		
Duragesic			Oxycodone			Valium		
Elavil			Oxycontin			Vicodin		
Flexeril			Predisone			Vioxx		

Allergies

Please list all medications you have allergies to and the type of reaction

Medication	Type of Reaction
______________	______________________________
______________	______________________________
______________	______________________________
______________	______________________________
______________	______________________________

I have personally reviewed and discussed the medication information with my patient.

Physician Signature ______________________________________ Date ____________