

HISTORY OF PRESENT ILLNESS

NAME: _____ BIRTHDATE: _____ TODAYS DATE: _____

1) WHAT IS THE REASON FOR TODAY'S VISIT?

2) HAVE YOU HAD A PROCEDURE SINCE YOUR LAST VISIT? Y/ N _____

3) HAS YOUR PAIN CHANGED SINCE YOUR LAST VISIT? NO YES

4) CHECK ANY OF THESE WORDS THAT DESCRIBE YOUR PAIN:

<input type="checkbox"/> ACHING	<input type="checkbox"/> PRESSURE
<input type="checkbox"/> BURNING	<input type="checkbox"/> SHARP
<input type="checkbox"/> CRAMPING	<input type="checkbox"/> SHOOTING
<input type="checkbox"/> GNAWING	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> PINS AND NEEDLES	_____

PAIN SCALE - WHAT IS THE LEVEL OF YOUR PAIN?

0-----10

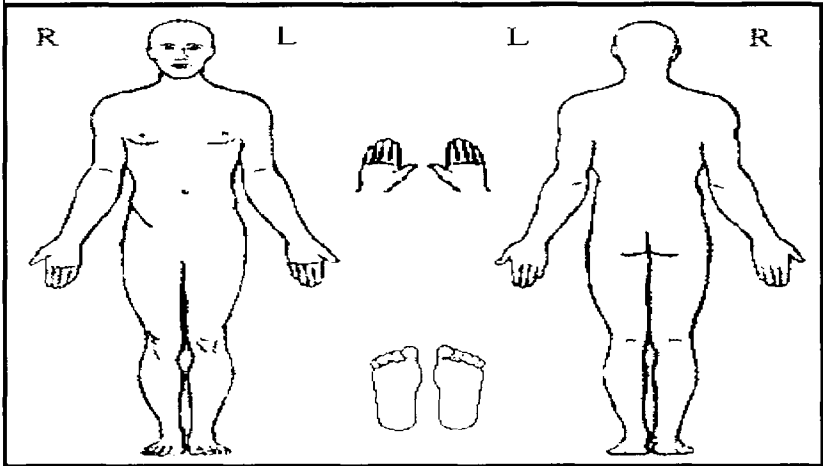
5) HOW DOES PAIN AFFECT LEVEL OF ACTIVITY?
 MILD MODERATE SEVERE VERY SEVERE

6) DOES PAIN EFFECT YOUR SLEEP?
 UNCHANGED IMPROVED WORSE
 DOES NOT INTERFERE

7) IS YOUR PAIN ASSOCIATED WITH ANY OF THE FOLLOWING:
 (If yes, tell us what body part has the symptom.)
 WEAKNESS: _____
 TINGLING: _____
 NUMBNESS: _____
 ARE ANY OF THESE SYMPTOMS NEW? _____

6) WHAT PAIN MEDICATIONS DO YOU TAKE AND DO THEY HELP?
 1) _____
 2) _____
 3) _____
 4) _____

SHADE THE AREAS YOU ARE HAVING PAIN ON THIS DIAGRAM:



7) WHAT OTHER TREATMENTS HAVE YOU USED IN THE PAST MONTH AND DID THEY HELP?
 1) _____ NO YES
 2) _____ NO YES
 3) _____ NO YES

8) HAVE YOU HAD ANY NEW TESTS SINCE YOUR LAST VISIT? NO YES

<input type="checkbox"/> X-RAY	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> MRI	_____
<input type="checkbox"/> CATSCAN	
<input type="checkbox"/> EMG	

SINCE YOUR LAST VISIT:
 (IF YOU ANSWER YES TO ANY OF THE QUESTIONS, PLEASE LIST WHY)
 A) ANY CHANGES IN YOUR MEDICAL CONDITION?
 NO YES

B) ANY CHANGES IN ANY OF YOUR MEDICINES?
 NO YES

C) ANY CHANGES IN YOUR FAMILY STATUS, SMOKING OR ALCOHOL INTAKE?
 NO YES

D) HAVE YOU RECEIVED ANY PAIN MEDICINE FROM ANOTHER DOCTOR OR ER?
 NO YES