PATIENT HISTORY

Name:_____Age:_____Date:_____

Chief Complaint / Current Problems: (eg., head, neck, back, arm, leg, hand pain, etc.) _____

_____

_____

_____

_____

How long have you been experiencing this pain ?

_____

Are you currently out of work or on light duty restrictions for this condition ?

_____

First day out of work due to this

disability: _____

How have you had to alter your life style due to your condition. (ie: housework, sports etc.)

_____

_____

_____

If this problem is due to an accident or injury please explain: (Auto, Work or Personal Injury etc.)

_____

_____

Date of Injury:_____

Have you had any treatment for this problem in the past ? Please explain.

_____

_____

_____

Are you currently on disability ? If so short term or permanent disability?

_____

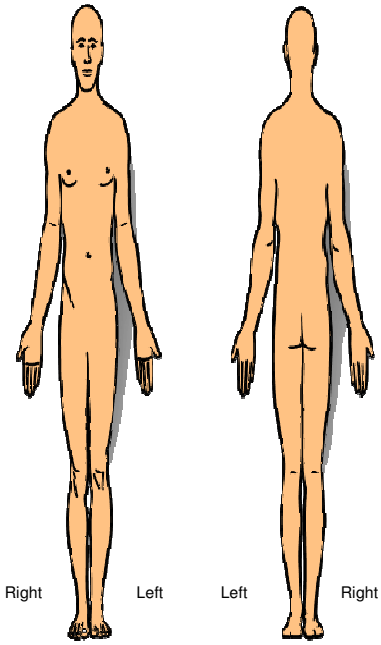
_____

Pharmacy Name and phone number ?

_____

_____

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.



For ache use: ^^^^^^

For numbness use: ooooo

For tingling/pins & needles use: ++++

For Burning use: xxxx

For Radiating Pain: / / / / / /

On a VA Scale of 0-10 how is your back /neck pain now ?

_____

How bad is your extremity pain now ?

_____

I can tolerate my pain at a pain score of (1 being the best and 10 being the worst) ?

_____

Please Circle the duration of Pain:

Continuous

Positional

Intermittent (on/off)

Referred By:

Physician: _____

Specialty: _____

Address: _____

_____

Phone: _____

Fax: _____

Internist/Primary Care Physician:

Physician: _____

Specialty: _____

Address: _____

_____

Phone: _____

Fax:_____

Other Doctor(s) involved in your care:

Physician: _____

Specialty: _____

Address: _____

_____

Phone: _____

Fax: _____

RN Case Manager (if applicable):

Name: _____

Address: _____

_____

Phone: _____

Fax:_____

Are you represented by an attorney due to an injury? Are your complaints today related to the injury in question ?

_____

_____

If so please ask for an attorney Information form if you want him/her to get a copy of the office visit notes.