PAIN SPINE & REHAB ASSOCIATES

501 North Frederick Avenue
Suite 302
Gaithersburg, MD 20877

Tel 301.591.8261
Fax 301.591.8262
www.painspineandrehab.com

Date ___ /___ /_____
How did you hear about us? _____
_____

NEW PATIENT HISTORY & PHYSICAL FORM

Primary Doc
_____

Referring Doc (if different from above)
_____

Last Name _____ First Name _____DOB ____ / ____ / _____

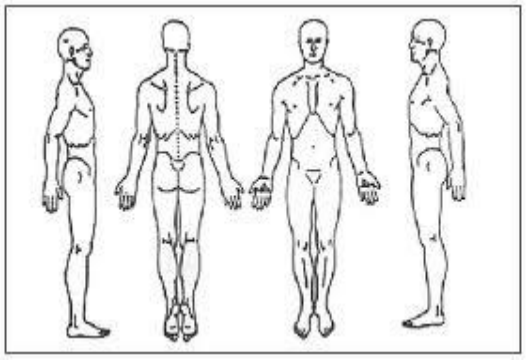
HISTORY OF PAIN AND SPINE SYMPTOMS

When did your current pain problem begin?

___ /___ /_____ or

_____ years / months ago

How has the pain changed or evolved since it first started:



Please indicate your main area of pain on the diagram. Describe it here if needed:
_____
_____
_____
_____

__ improved __ worsened __ stayed the same __ improved then came back __ other _____

How did your pain begin?

__ work injury __ injury, not at work __ motor vehicle accident __ post-treatment (surgery or procedure)

__illness __ unknown __ other: _____

How often do you have your pain? __ constantly __ frequently __ occasionally __ only when I am _____

Please indicate the following other symptoms that you may have:

__ back pain __ leg pain __ tingling/numbness in leg __ whole body pain __ pain in joints

__ neck pain __ arm pain __ tingling/numbness in arm __ abdominal pain __ other _____

Is your pain interfering with any of the following? __ bladder __ bowel __ walking __ sexual intercourse

Is your sleep affected by your pain? __ yes __ no __ if yes, how? _____

Please rate (circle) your pain level today on a scale of 0 to 10, with 0 being "*no pain*" and 10 being the "*worst pain you can imagine*"

0 1 2 3 4 5 6 7 8 9 10

Characteristics of your pain: __ burning __ stabbing __ throbbing __ aching __ electric/shock-like

__ dull __ sharp __ shooting __ pins & needles __ other _____

Please indicate whether the following increase (I), decrease (D) or do not affect (X) your pain levels:

__ liquor __ caffeine __ eating __ heat __cold __ damp __ weather changes

__ massage __ pressure __ movement __ sitting __ standing __ tension __ physical activity

__ urination __ bowel movt __ loud noises __ sneezing __ coughing __ sex __ distractions (TV, etc.)

__ sleep/rest __ bright lights __ lying down __ fatigue __ bending __ lifting __ twisting (L / R / both)

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PAST TREATMENT HISTORY

Have you ever been treated by a pain management specialist? __ yes __ no Doctor _____ Date_____

Have you ever had back or neck surgery? __ yes __ no Doctor _____ Hospital_____ Date_____

Please indicate below which (if any) treatments you have had for this pain. *[If not done then leave blank, if NONE then mark here __]*

Treatment	Relief? (Y/N)	Date Performed	Provider	Contact # for Records
Nerve blocks				
Epidural steroid injections				
Facet/Medial branch blocks				
Radiofrequency denervation/ablation				
Trigger point injections				
Spinal Cord Stimulator trial/implant				
Modalities (TENS, LSO, traction collar)				
Acupuncture				
Other_____				

Please indicate approximate dates & locations for any tests you have had. *[If not done then leave blank, if NONE then mark here __]*

	TEST	Date		Facility	
	CT Scan	/ /			
	MRI	/ /			
	X-ray	/ /			
	Ultrasound	/ /			
	EMG/NCS	/ /			
	Bone scan	/ /			
	CT Myelogram	/ /			
	Lumbar Puncture	/ /			
	Other_____	/ /			

Please indicate which types of specialists you have seen for this problem. *[If not seen then leave blank, if NONE then mark here __]*

	SPECIALIST	Date of Evaluation	Name and Contact Information
	Neurology	/ /	
	Neurosurg/Ortho Spine	/ /	
	Orthopedic Surgery	/ /	
	Psychiatry	/ /	
	Chiropractic	/ /	
	Physical Therapy	/ /	
	Aquatic Therapy	/ /	
	Massage Therapy	/ /	
	Other _____	/ /	

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CURRENT & PAST MEDICAL/SURGICAL HISTORY

Please list all drug allergies:

_____

_____

_____

Do you have allergies to:

__ Latex __ Iodine __ X-ray dye

Current medications: name, dose (mg), how often

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you currently take? __ Coumadin __ Aggrenox __ Plavix __ Lovenox __Xarelto __Aspirin 325mg

Are you on (or have you been on) any other blood thinners not mentioned above? List them here _____

Please check if you currently have or have had any of the following medical conditions *[If none then leave blank and mark here ___]*

Cardiac
__ CAD
__ heart murmur
__ high blood pressure
__ high cholesterol
__ CHF
__ angina
__ deep vein thrombosis
__ arrhythmia
__ heart attack

Musculoskeletal
__ fibromyalgia
__ chronic fatigue
__ osteoarthritis
__ rheumatoid arthritis
__ Systemic lupus (SLE)

Endocrine
__ diabetes Type 1
__ diabetes Type 2
__ hypothyroidism
__ hyperthyroidism

Pulmonary
__ bronchitis
__ COPD
__ pulmonary embolism
__asthma
__ TB
__ pneumonia
__ sleep apnea
__ emphysema

Neurological
__ multiple sclerosis
__ stroke
__ migraines
__ tension headaches
__ seizures

Renal
__ kidney stones
__ renal failure
__ UTI's
__ incontinence

ENT
__ hay fever
__ sinus infections
__ ear infections

GI
__GERD
__ IBS
__ cirrhosis
__ gallbladder disease
__ hepatitis A/B/C
__ ulcers
__ Crohn's disease
__ulcerative colitis

Mental Health
__ anxiety
__ bipolar
__depression

Hematologic
__ iron def. anemia

PLEASE LIST ANY SURGERIES YOU HAVE HAD (with dates):
_____

_____

_____

_____

_____

_____

FAMILY HISTORY *[Please indicate affected family member: M = mother, F = father, G = grandparent, S = sibling, C = child, O = other]*

back/neck surgery _____ chronic pain_____ chronic fatigue or fibromyalgia _____ migraines_____

kidney problems _____ high blood pressure _____ diabetes(Type 1 or 2 _____ heart disease_____

Cancer (which kind) _____bleeding disorder_____ stroke_____ asthma_____

SOCIAL HISTORY

Highest Level of Education __ High school __Undergraduate __ Graduate Degree _____

Occupation _____ Retired? _____ Disabled? _____ Other _____

__Divorced __Married __Separated __Single __Widowed # of children___ Who lives with you?_____

Alcohol? __ Y __ N __ Occasional __ Daily __ Past alcoholic Smoker? __ Y __ N How many packs a day? _____ Years? _____

Which ones have you used? __ Meth __ Cocaine __ Marijuana __ Heroin __ Crack Currently? __Y __N

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REVIEW OF SYSTEMS Please mark the symptoms you are experiencing. *[If not recently then leave blank, if none then mark here __]*

General *[None __]*
__ Fatigue
__ Fever
__ Weakness
__ Night sweats
__Chills
__ Other _____

Eyes *[None __]*
__ Blurred vision
__ Photophobia
__ Vision changes
__ Tearing
__ Glasses/contacts
__ Other _____

Ears/Nose/Throat *[None __]*
__ Hearing changes
__ Bleeding gums
__ Periodontal disease
__ Sore throat
__ Difficulty swallowing
__ Swollen neck
__ Masses
__ Hoarseness
__ Other _____

Cardiovascular *[None __]*
__ Palpitations
__ Edema
__ Rapid heartbeat
__ Heart murmur
__ Leg swelling/pain
__ Leg pain when walking
__ High blood pressure
__ High cholesterol
__ Abnormal heart rhythm
__ Pacemaker
__ Congestive heart failure
__Chest Pain
__ Other _____

Hematologic *[None __]*
__ Easy bruising
__ Excessive bleeding
__ Swollen glands
__ Other _____

Urinary *[None __]*
__ UTI's
__ Urinary incontinence
__ Pain with urination
__ Frequent night time urination
__ Stones
__ Other _____

Musculoskeletal *[None __]*
__ Muscle pain
__ Back pain
__ Joint pain/stiffness
__ Limb pain
__ Reduced range of motion
__ Swelling/redness of joints
__ Muscular Dystrophy
__ MS
__ Other _____

Skin *[None __]*
__ Jaundice
__ Itching
__ Rashes
__ Hair/nail changes

Neurological *[None __]*
__ Seizures
__ Weakness
__ Headaches
__ Loss of sensation
__Numbness/tingling
__ Paralysis
__ Tremors
__ Fainting/blackouts
__ Stroke
__ Head injury
__ Scoliosis
__ Other _____

Endocrine *[None __]*
__ Heat/cold intolerance
__ Excessive thirst
__ Hair loss
__ Excessive sweating
__ Low blood sugar
__ Other _____

Allergic/Immunologic *[None __]*
__ Frequent upper respiratory infections
__ Seasonal allergies
__ HIV/AIDS
__ Swollen glands
__ weak immune system
__ Other _____

Psychiatric *[None __]*
__ Anxiety
__ Depression
__ Sleep disturbance
__ Suicidal thoughts
__ History of abuse
__ Stress/tension
__ ADHD
__ Panic attacks
__ Other _____

Respiratory *[None __]*
__ Cough
__ Shortness of breath
__ Wheezing
__ Coughing up blood
__ Bronchitis
__ Sleep apnea
__ Other _____

Gastrointestinal *[None __]*
__ Nausea
__ Diarrhea
__ Constipation
__ Abdominal pain
__ Decreased appetite
__ Acid reflux
__ Irregular bowel movements
__ Vomiting blood
__ Bloody stools
__ Black/tarry stools
__ Ulcers
__ Hernia
__ Vomiting
__ IBS
__ Other _____

ADDITIONAL NOTES OR SYMPTOMS: _____
_____
_____
_____