

DR. RUTH ANDERSON
PATIENT HISTORY FORM- 6 MONTH FOLLOW-UP/NEW PAIN

DATE: _____

NAME: _____ PHONE: _____

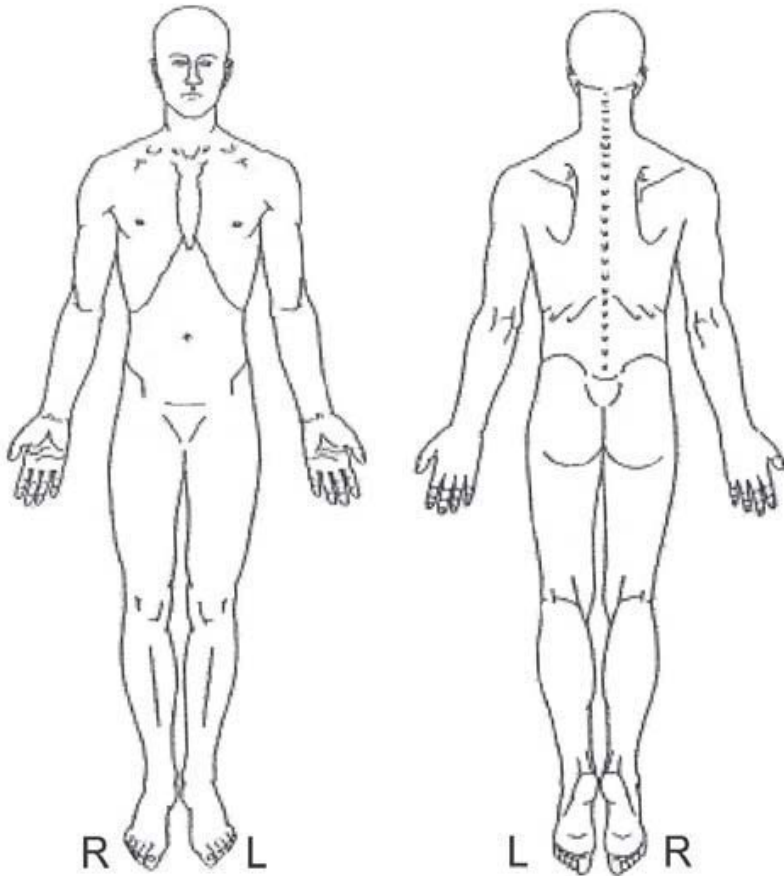
DATE OF BIRTH: _____

REASON FOR YOUR VISIT: _____

HISTORY OF PRESENT ILLNESS

AGE _____ RACE _____ SEX M F

PLEASE DRAW WHERE YOUR PAIN IS LOCATED:



PLEASE DESCRIBE YOUR PAIN:

CONSTANT

INTERMITTENT

BURNING

DEEP/DULL ACHE

FIRE

THROBBING/JABBING

ELECTRIC

SPASM

SHOOTING

TOOTHACHE

KNIFE-LIKE

PLEASE LIST ASSOCIATED SYMPTOMS:

- MUSCLE SPASM NUMBNESS
- NAUSEA/VOMITING TINGLING
- RESTLESS LEGS SWELLING
- FATIGUE
- LEG CRAMPS
- FOOT DROP
- LIGHTHEADEDNESS SENSITIVITY TO LIGHT
- VISUAL DISTURBANCES PRIOR TO HEADACHE
- PAIN WITH FIRST STEPS IN THE MORNING
- PAIN THAT WAKES YOU UP AT NIGHT

STIFFNESS: () LOW BACK () LEGS () KNEES () HIPS () FEET () NECK () ARMS
() SHOULDERS () HANDS

TENDERNESS: () LOW BACK () LEGS () KNEES () HIPS () FEET () NECK () ARMS
() SHOULDERS () HANDS

WEAKNESS: () LOW BACK () LEGS () KNEES () HIPS () NECK () ARMS
() SHOULDERS () HANDS

PLEASE RATE YOUR PAIN :

0-10 SCALE, WHERE 0/10=NO PAIN AND 10/10 IS SO SEVERE YOU CAN'T EVEN SPEAK

CURRENT PAIN: ____/10 WORST PAIN: ____/10 'BEST DAY' PAIN: ____/10

WAS YOUR ONSET OF PAIN ____ GRADUAL OR ____ SUDDEN?

WHEN DID YOUR PAIN FIRST OCCUR (APPROXIMATE DATE): _____

WERE YOU INJURED OR IN AN ACCIDENT THAT CAUSED YOUR PAIN TO OCCUR:

WHAT MAKES YOUR PAIN BETTER?

- LYING DOWN SITTING GETTING OUT OF A CHAIR
- BENDING FORWARD STANDING
- WALKING REACHING TURNING MY HEAD
- EXERTION/EXERCISE COMPUTER WORK
- TWISTING TWISTING
- CHANGING POSITIONS LEANING ON A SHOPPING CART
- HEAT ICE
- OTHER, PLEASE EXPLAIN: _____

WHAT MAKES YOUR PAIN WORSE?

- LYING DOWN SITTING GETTING OUT OF A CHAIR
- BENDING FORWARD STANDING
- WALKING REACHING TURNING MY HEAD
- EXERTION/EXERCISE COMPUTER WORK
- TWISTING TWISTING
- CHANGING POSITIONS LEANING ON A SHOPPING CART
- HEAT ICE
- OTHER, PLEASE EXPLAIN: _____

MY PAIN IS WORSE IN THE: ____ MORNING ____ NOON ____ EVENING ____ DURING SLEEP

PLEASE CHECK ALL TREATMENTS YOU HAVE TRIED AND THEN INDICATE IF THEY WERE HELPFUL OR NOT

	Helpful	Not Helpful	Details
Ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Biofeedback/ Relaxation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Home Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Accupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Laser Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Nerve Blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
TENS/ MENS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Trigger Point Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Epidurals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Pain Management Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

PLEASE CHECK ALL MEDICATIONS THAT YOU HAVE TRIED AND WHETHER THEY WERE HELPFUL OR NOT

ANTI-INFLAMMATORY MEDICATION

NSAIDs	Helpful	Not Helpful	Details
Advil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Aleve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Celebrex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Diclofenac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Mobic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

MUSCLE RELAXANTS

Muscle Relaxants	Helpful	Not Helpful	Details
Flexeril	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Soma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Skelaxin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Zanaflex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

NARCOTIC PAIN PILLS

Short Acting Narcotics	Helpful	Not Helpful	Details
Tramadol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Vicodin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Perocet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Darvocet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Actiq	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Dilaudid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Long Acting Narcotics	Helpful	Not Helpful	Details
Duragesic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Morphine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
OxyContin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

DURING THE PAST MONTH, HOW MUCH DID YOUR PAIN INTERFERE WITH:

	Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
Going to Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performing Household Chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yard Work or Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socializing With Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation & Hobbies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having Sexual Relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PERSONAL MEDICAL HISTORY

ARE YOU DIABETIC? Y N

DO YOU HAVE GLAUCOMA? Y N

ARE YOU ON A BLOOD THINNER? Y N

IF SO, FOR WHAT CONDITION? _____

WHAT OTHER MEDICAL CONDITIONS ARE YOU BEING TREATED FOR?

PLEASE LIST ANY SURGERIES YOU HAVE HAD:

SURGERY

YEAR OF SURGERY

LIST ALL ALLERGIES AND YOUR REACTION

ARE YOU ALLERGIC TO:

IODINE? Y N
LATEX? Y N
SHELLFISH? Y N
SEAFOOD? Y N

WHAT OTHER ALLERGIES DO YOU HAVE?

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING - PROVIDE COMPLETE LIST INCLUDING SUPPLEMENTS

<u>NAME</u>	<u>STRENGTH (MG)</u>	<u>HOW OFTEN YOU TAKE IT</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

MARITAL STATUS: S M D W HOW MANY CHILDREN DO YOU HAVE? ____

WHAT IS YOUR LEVEL OF EDUCATION? _____

OCCUPATION: _____

DISABLED: _____ HOW LONG: _____

DO YOU SMOKE: Y N HOW MUCH: _____ HOW LONG: _____

DO YOU DRINK ALCOHOL: _____ NUMBER OF DRINKS/WEEK: _____

HAVE YOU HAD AN EMOTIONAL DISTURBANCE IN THE PAST: Y N

HAVE YOU BEEN PHYSICALLY ABUSED: Y N

HAVE YOU BEEN EMOTIONALLY ABUSED: Y N

DO YOU HAVE A HISTORY IN YOUR FAMILY OF ALCOHOL, PRESCRIPTION DRUG OR ILLEGAL DRUG ABUSE? Y N

REVIEW OF SYSTEMS

PLEASE CIRCLE ALL SYMPTOMS YOU HAVE EXPERIENCED RECENTLY

FEVER, CHILLS, WEIGHT LOSS OR WEIGHT GAIN

HEARING LOSS, VISION CHANGES

SHORTNESS OF BREATH, COUGH

CHEST PAIN, PALPITATIONS, RACING HEART

NAUSEA, VOMITING, DIARRHEA, CONSTIPATION, HEART BURN

NEW SKIN RASH, EASY BRUISING,

NEW JOINT PAIN, MUSCLE WEAKNESS

DIZZINESS, HEADACHE, WEAKNESS, LOSS OF CONSCIOUSNESS