**ADVANCED INTERVENTIONAL PAIN CONSULTANTS Initial Consultation**

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age** \_\_\_\_\_  **Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRING PHYSICIAN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PRIMARY CARE DOCTOR** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your **main pain complaint**? Circle what applies

**Low-back Mid-back Neck Head Joints** Hip Knee Shoulder **Muscles** **Other**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

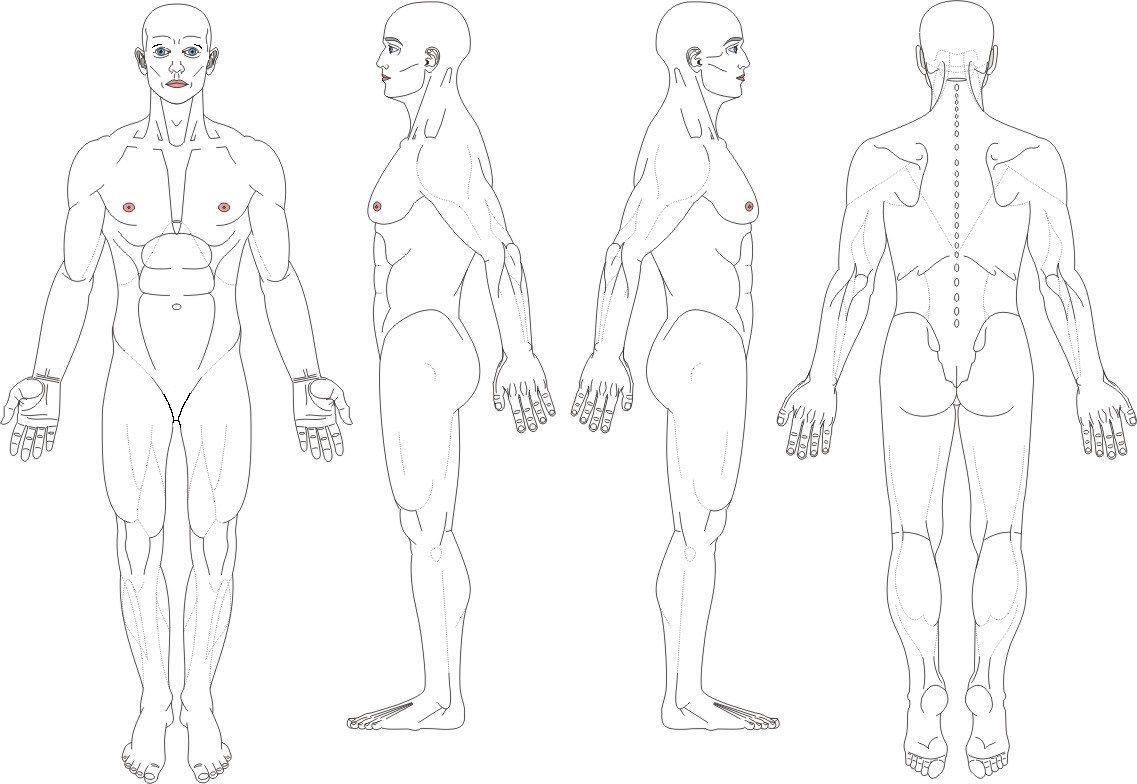
**HISTORY OF PRESENT ILLNESS**

**When** did the pain start? How many days/months/years ago or date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

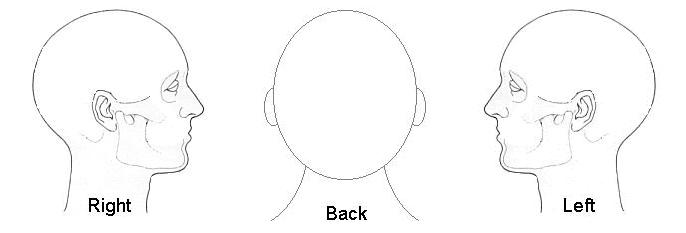
Where you involved in a **motor vehicle accident**? Yes\_\_\_ No\_\_\_ Did you sustain a **work related injury**? Yes\_\_\_ No\_\_\_

**How** did the pain start? Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_

**Where** is your pain located? Marked in the diagram where your pain is present.

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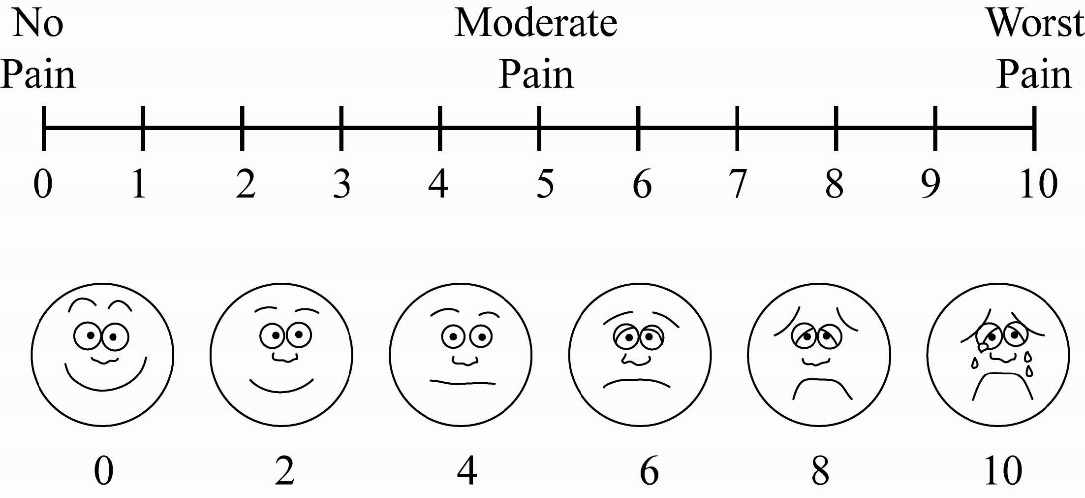
If you are being consulted for **headaches**, mark which areas are affected and where the pain radiates



How many headaches do you get per week? \_\_\_\_\_ How many per month? \_\_\_\_\_

**Numeric Pain Scale**

**How intense** is your pain? Circle the lowest level and the highest level

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How do you best **describe** your pain? What is the **pattern** of your pain?

Dull Electrical Constant

Sharp Burning Intermittent

Stabbing Shock-like Mornings Afternoons Nights

Aching Throbbing

Any **associated symptoms** \_\_\_ Numbness \_\_\_ Tingling \_\_\_ Weakness \_\_\_ Muscle spasms

Does the pain **radiate** to other areas? Yes No If yes, where does the pain **radiate**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the pain **worse**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the pain **better**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Overtime, is the pain getting? Better Worse About the same

What **medications** have you used in the past for pain relief?

Opioids \_\_\_ Morphine (Avinza, Kadian, MS Contin)

\_\_\_ Oxycodone (Oxycontin, Percocet, Percodan, Endocet)

\_\_\_ Codeine (Tylenol #3 or #4)

\_\_\_ Hydrocodone (Vicodin, Norco, Vicoprofen, Lortab, Lorcet, Zohydro)

\_\_\_ Tramadol (Ultram)

\_\_\_ Hydromorphone (Dilaudid, Exalgo)

\_\_\_ Oxymorphone (Opana)

\_\_\_ Fentanyl (Duragesic, Fentora, Actiq)

\_\_\_ Tapentadol (Nucynta)

\_\_\_ Buprenorphine (Butrans, Subaxone, Subutex)

\_\_\_ Methadone (Dolophine)

Anti-inflammatories \_\_\_ Ibuprofen (Motrin, Advil), Naproxen (Naprosyn, Anaprox, Naprelan, Aleve), Meloxicam (Mobic), Piroxicam (Feldane), Celecoxib (Celebrex), Etodolac, Doclofenac (Voltaren)

Nabumetone (Relafen)

Muscle relaxants \_\_\_ Carisoprodol (Soma), Baclofen, Cyclobenzaprine (Flexeril, Amrix),

Metaxalone (Skelaxin), Tizanidine (Zanaflex), Methacabamol (Robaxin)

Anticonvulsants \_\_\_ Gabapentin (Neurontin), Pregabalin (Lyrica), Topiramate (Topamax), Carbamazepine (Tegretol), Oxcarbazepine (Trileptal), Phenytoin (Dilatin), Lamotrigine (Lamictal)

Antidepressants \_\_\_ Duloxetine (Cymbalta), Venalafaxine (Effexor), Desvenlafaxine (Prestiq), Milnacipran (Savella), Amitriptyline (Elavil), Nortriptyline (Pamelor), Fluoxitine (Prozac), Citalopram (Celexa), Sertaline (Zoloft), Trazadone (Desyrel), Mitarzipine (Remeron), Bupropion (Wellbutrin)

Benzodiazepines \_\_\_ Alprazolam (Xanax), Lorazepam (Ativan), Diazepam (Valium), clonazepam (Klonopin)

Sleep aids \_\_\_ Zolpidem (Ambien), Eszopiclone (Lunesta), Zaleplon (Sonata), Ramelteon (Rozeram),

over the counter sleep aids

Have you been treated by a **pain management doctor**(s) before? \_\_\_ No \_\_\_ Yes

List the doctor(s) name(s) and dates? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had any **pain injections** done? \_\_\_ No \_\_\_ Yes If yes, what type of injections and date of the injections?

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Have you had a **spinal cord stimulator trial**? \_\_\_ No \_\_\_ Yes

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who performed the trial? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a **spinal cord stimulator permanently placed**? \_\_\_ No \_\_\_ Yes

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who performed the placement?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a **pain pump** implanted? \_\_\_ No \_\_\_ Yes

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who performed the placement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated by a **spine surgeon**, **neurosurgeon** or **orthopedic surgeon**? \_\_\_ No \_\_\_ Yes

What is the name of the doctor(s) and dates? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had **neck or back surgery**? \_\_\_ No \_\_\_ Yes

What type of surgery and dates of the surgery? 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What **other treatment modalities** have you tried?

**Date Helped No change**

\_\_\_ Acupuncture \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

\_\_\_ Massage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_ Hot packs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_ Cold packs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

\_\_\_ Physical therapy

Standard \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

Aquatic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

Traction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

\_\_\_ TENS units \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

**Date Name Helped No change**

\_\_\_ Chiropractor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

\_\_\_ Psychological

Counseling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

Biofeedback \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

Cognitive \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

How does **pain affect** your life style? Explain

\_\_\_ Family life/marriage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Ability to work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Ability to sleep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Activities of daily living \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Sex life \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST SURGICAL HISTORY** List all surgeries and dates

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY**

Heart disease \_\_\_ Congestive heart failure \_\_\_ Coronary artery disease \_\_\_ Heart attacks

\_\_\_ Bypass surgery \_\_\_ Coronary stents

Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke Transient ischemic attack\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COPD Asthma Emphysema \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Liver disease Cirrhosis Hepatitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizures \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fibromyalgia Rheumatoid arthritis Ankylosing Spondylitis Lupus Psoriatic arthritis

Osteoarthritis Osteoporosis Fibromyalgia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Multiple sclerosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Headaches \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression Anxiety Bipolar disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **ALLERGIC** or sensitive to any medications? \_\_\_ No \_\_\_ Yes List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What **MEDICATIONS or TOPICAL CREAMS for PAIN** are you currently using? Include dosage and times per day taken

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all other **MEDICATIONS** are you currently taking. Include dose and times per day taken

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any of the following **blood thinners**? \_\_\_ Plavix \_\_\_ Coumadin \_\_\_ Lovenox \_\_\_ Heparin

\_\_\_ Aspirin \_\_\_ Digabatran (Vigabatin) \_\_\_ Apixoban (Elquis) \_\_\_ Rivaroxaban (Xarelto) \_\_\_ Edoxaban (Lixiana) \_\_\_ Alteplase (Aclilyse) \_\_\_ Ticlopidine (Ticlid)

**SOCIAL HISTORY**

Are you employed? \_\_\_ No \_\_\_ Yes Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you disabled? \_\_\_ No \_\_\_ Yes Since when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Separated

How many children do you have? \_\_\_\_ What are their ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink? \_\_\_ No \_\_\_ Yes How many drinks per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? \_\_\_ No \_\_\_ Yes How many cigarettes or packs per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke marijuana? \_\_\_ No \_\_\_ Yes

Do you currently use or have you ever used illegal drugs \_\_\_ No \_\_\_ Yes

Have you ever abused narcotics or prescription medications? \_\_\_ No \_\_\_ Yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of a psychiatrist or psychologist? \_\_\_ No \_\_\_ Yes

If yes, what is the name of your psychiatrist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any significant traumatic events in your life \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY HISTORY**

Does anyone in your family have a history of back or neck pain, depression, anxiety, or substance abuse (alcohol or drugs)? \_\_\_ No \_\_\_ Yes

If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**REVIEW OF SYSTEMS Circle all that apply** \_\_\_\_ No problems

**1. General**  Weight gain or loss, unexplained hair loss, fever or chills, low energy, too sleepy

**2. Eyes/ Ears/Nose/Throat**  Eye pain, vision problems (blurred vision, loss of vision), hearing loss, swollen glands in neck, sore throat/pain when swallowing, dental problems

**3. Cardiovascular**  Chest pain (sharp, crushing, or heaviness), heart racing (palpitations), fainting spells, shortness of breath, swelling of legs (edema)

**4. Respiratory** Shortness of breath, cough/coughing up blood

**5. Gastrointestinal**  Increased appetite,decreased appetite, stomach pain, nausea/vomiting, diarrhea, constipation

**6. Genitourinary**   Pain when passing water (urination), blood in urine, urinating more than usual (day and/or night), bladder Infection,pain during sex, changes in sex drive (libido)

**7. Musculoskeletal** Limited motion of arms or leg, joint pain, swelling/redness, numbness, tingling, or weakness in arms or legs

**8. Neurological**  Arm/leg weakness,new headaches, problems with memory or speech, tremors

**9. Psychiatric**  Sadness, stress, seeing or hearing things, suicidal thoughts, feeling down, insomnia

**10. Endocrine**  Weight gain/loss,thirsty all the time, cannot stand temperature changes (heat/cold)

**11. Lymph**  Swollen glands (armpits or groin)

**12. Skin** Rash (palm of hands, sole of feet), changes in skin, sores or rash on skin

**13. Allergies**  Hives/skin rashes, allergic reaction to foods

I attest that ALL information I have provided is accurate and factual, and I can provide supporting information.

**Patient‘s Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_