

Patient Name: _____ *Medical History Intake Form*
 Date of Birth: ____/____/____ Age: ____ MR#: _____

Today's Date ____/____/____
 Referral Source: _____

CC: What problem/issue brings you here today?

HPI: How and when did it start?

What makes it worse?	walking	sitting	standing	lying down	nothing	exercise	Other:
What makes it better?	walking	sitting	standing	lying down	nothing	exercise	Other:
What do you want to accomplish from today's visit?	Diagnosis	Treatment Options	X-ray Rx	MRI Rx	Med Rx	Review Test	Injection Rx
What diagnostic tests have you had for this problem?	None	X-ray	MRI	CT scan	Ortho consult	EMG	
What treatments have you had?	None	Massage	Meds	Injections	Physical Therapy	Psychotherapy	Chiro

Please make a mark on the line below to indicate the level of discomfort you have today.

No Pain _____ Worst Pain Ever
 0 1 2 3 4 5 6 7 8 9 10

Please describe what the pain feels like: Dull | Achy | Burning | Stabbing | Numb | Tingling | Pulling | Cramping | Stiff | Tight

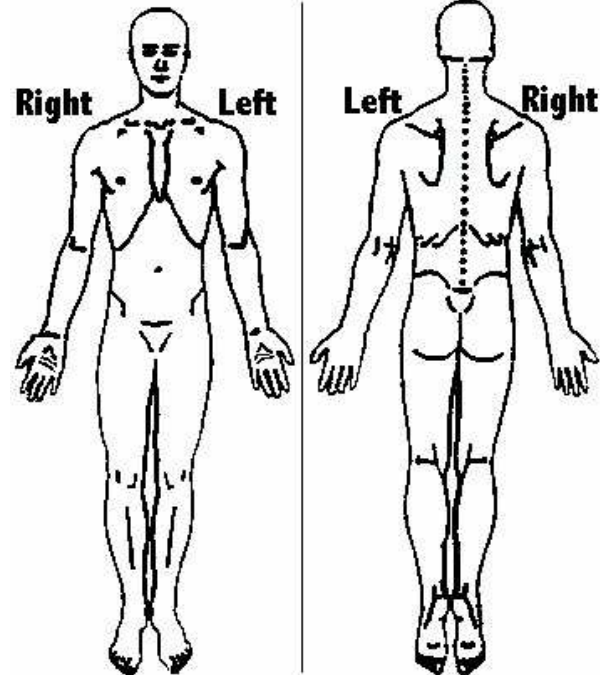
Please describe the time course of your pain: Constant | Comes and goes (fluctuating) | Worsening | Improving | Staying the same

Review of Systems

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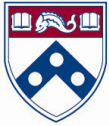
Fevers, unintentional weight change?	Yes	No
Vision change, double vision?	Yes	No
Difficulty swallowing, headaches?	Yes	No
Chest pain, palpitations?	Yes	No
Shortness of breath, wheezing, cough after exercise?	Yes	No
Nausea, vomiting, black stools, loss of control of stools?	Yes	No
Loss of control of urine, urinary frequency or urgency?	Yes	No
New rashes or psoriasis or skin lesions?	Yes	No
Dizziness, weakness, numbness, tingling?	Yes	No
Depressed mood, sleep problems, anxiety?	Yes	No
Current low back pain, other joint swelling or muscle pain?	Yes	No
Are you pregnant, trying to get pregnant or breastfeeding?	Yes	No
Last menstrual period date: _____	Periods regular?	Yes No

Please draw where your pain is:



Patient's Signature: _____

Physician Initials/Date/Time: _____/_____/_____



Pain Disability Index

Patient Name: _____ MRN: _____

Date: ____/____/____

Date of Birth: ____/____/____

In order to determine how effective your treatment is, we need to know how much pain is interfering in your normal activities. Please select the number on the scale which describes the level of disability you have experienced in each area OVER THE PAST WEEK.

A score of "0" means no disability at all, and a score of "10" indicates that all of the activities which you would normally do have been totally disrupted or prevented by your pain over the past week. Circle "0" if a category does not apply.

FAMILY/HOME RESPONSIBILITIES: This category refers to activities related to the home or family. It includes chores or duties performed around the house (e.g., yard work, house cleaning) and errands or favors for other family members (e.g., driving the children to school).

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

RECREATION: This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

SOCIAL ACTIVITY: This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

OCCUPATION: This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as housewife or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

SEXUAL BEHAVIOR: This category refers to the frequency and quality of one's sex life.

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

SELF-CARE: This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed).

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

LIFE-SUPPORT ACTIVITY: This category refers to basic life-supporting behaviors such as eating and sleeping.

0 1 2 3 4 5 6 7 8 9 10
No Disability Mild Moderate Severe Total Disability

Office Use Scoring: Sum Total: ____/70