DATE__________________

NAME_______________________________________AGE_______HEIGHT______WT________

PAST MEDICAL HISTORY

☐High blood pressure ☐Heart disease ☐Diabetes Type1___Type 2____ ☐Bleeding ulcer ☐Reflux
☐Osteoporosis/osteopenia ☐ Kidney disease ☐Hypothyroidism ☐Lung disease (COPD, emphysema, asthma)
☐ Arthritis ☐Depression/anxiety ☐High cholesterol ☐Neck/Back Pain
☐Cancer(type)_________________________ ☐Other________________________
Previous Pain Management: ☐spinal injections ☐physical therapy ☐medications☐chiropractic☐acupuncture

PAST SURGICAL HISTORY (PLEASE LIST & PROVIDE DATES)

____
____
____

CURRENT MEDICATIONS AND DOSAGE

YOUR PHARMACY NAME TOWN PHONE NUMBER

____

ALLERGIES TO MEDICATIONS, CONTRAST DYE, LATEX

____

SOCIAL HISTORY

Marital Status________________Occupation____
Physical demands at work____
Smoking History: Never_________Quit_________Current smoker of ________packs/day
Recreational drugs use: Never_________Quit_________
Hobbies/Sports____
Exercise routine____

FAMILY HISTORY (Note immediate family member with any of the conditions below)

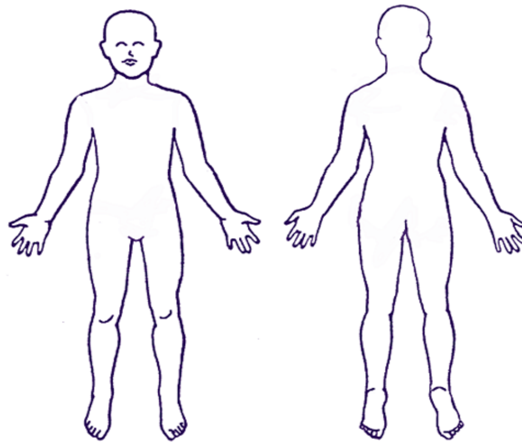
☐Heart disease____________☐Diabetes____________☐Cancer____________☐Arthritis____________
☐Neurological disorders(Stroke, MS)________________☐Osteoporosis_________

REVIEW OF SYSTEMS (please circle response)

CONSTITUTIONAL: Any recent changes in weight or appetitie? ________________________ Yes No
Any fevers, chills, sweats, fatigue?_______________________________ Yes No
SKIN: Do you have any rashes, sores, itching, changes in moles?_______________________ Yes No
ENT: Do you have any trouble with your vision or hearing?_____________________________ Yes No
RESPIRATORY: Do you have trouble breathing, persistent cough or phlegm? wheeze?______ Yes No
GI: Do you suffer from diarrhea, nausea, vomiting, constipation, bloody or black stools?_____ Yes No
GU: Do you have trouble starting or stopping you urine?______________________________Yes No
Do you lose your urine accidentaly?____ Yes No
Do you have frequency of urination, bloody or cloudy urine?_________________________ Yes No
Men: Do you have a discharge from your penis?_____________________________ Yes No

Women: Do you have any lumps, discharges, or pain in your breasts?____________ Yes No
Do you have any vaginal discharge?_______________________________ Yes No
If menopausal, age at menopause_________________
CARDIAC: Have you had chest pain, shortness of breath, palpitations?__________________ Yes No
Have you had a heart attack?____ Yes No
Have you had a stress test? If so, results__________________________________ Yes No
HEMATOLOGIC: Do you bruise or bleed easily? Do you have a low blood count?__________ Yes No
NEUROLOGIC: Do you have frequent headaches or migraines?_________________________ Yes No
Do you have any numbness or tingling in your arms or legs?_________________ Yes No
Do you have serious trouble with your memory?____________________________ Yes No
Have you had seizures, TIA, or a stroke?_________________________________ Yes No
ALLERGIC: Do you have any allergies or swollen glands_____________________________ Yes No
PSYCHIATRIC: Do you often feel depressed, sad, or anxious?__________________________ Yes No
Do you have trouble sleeping? _______________________________________ Yes No

On the diagram, shade in the areas where you feel pain. Put an X where it hurts the most.



Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24hours.____

No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain you can imagine

Please rate your pain by circling the one number that best describes the LEAST pain in the past 24 hours.____

No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain you can imagine