**Patient Name: _____** ***Medical History Intake Form*** **Today's Date____/____/____**

**Date of Birth: ____/____/____ Age: ___ MR#: 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 |
| **Is this a Worker's Compensation Claim or is there litigation pending?** | | | Yes | No | | | |
| **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

**What is your Occupation?**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Physical requirements:** | Prolonged Sitting | Prolonged Standing | Lifting | Travel | Driving | Computer | Phone | Childcare |
| **Employment status:** | Full-time | Part-time | Light Duty | Off Duty due to injury | Full-time Parent | Not working | Retired | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Number of alcoholic beverages per week?** | | **Illicit Drug Use or history of Substance Abuse?** | | | Yes | No |
| **Tobacco use** *(ie cigarette, cigar, pipe, chew)* | Current | Quit | Never | | | |

***Medications*** *(ie Prescription, Over-the-Counter (ie Advil, Aspirin), Supplements, Vitamins)*

***Medical/Surgical History (****ie Surgeries, Diabetes, Cancer, High blood pressure, Heart attack, Pacemaker, Arthritis, Fractures, Accidents, Osteoporosis)*

***Family History*** *(ie Cancer, Heart disease, Stroke, Arthritis, Osteoporosis)*

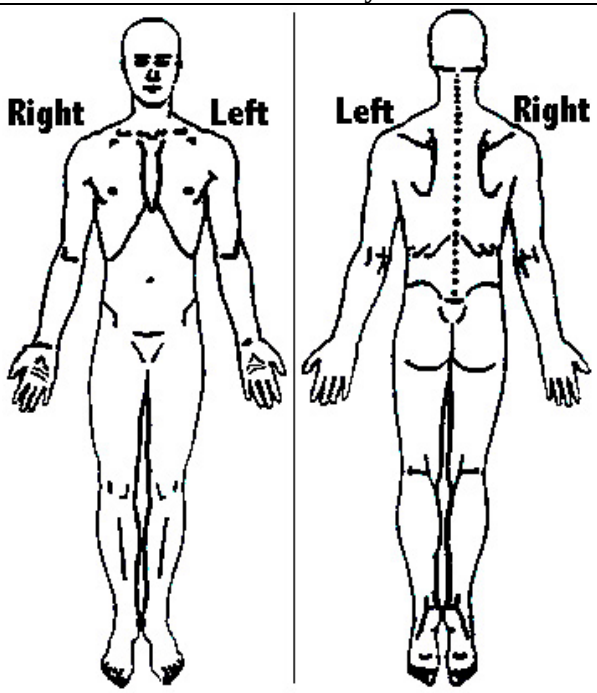
***Allergies*** **to medicines** *(ie penicillin, contrast, iodine):*

**What are you doing for exercise now?**

***Review of Systems***

| | | |
|---|---|---|
| **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 you have Pain**




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

## Patient Specific Functional Scale

Identify the most important activity that you are unable to do or are having difficulty with as a result of your current problem. Today, what activity are you unable to do or having difficulty with because of your current problem?_____

*(examples may include things like, "sitting for 1 hour", "standing for 1 hour", "picking up my child", "running for 30 minutes", "walking for 1 block".)*

*Please rate your ability to perform this functional activity now:

0 1 2 3 4 5 6 7 8 9 10

**Unable to perform** **Able to perform at prior level**

***** Note that this scale is rated on your ABILITY to do the activity – so it is reverse from the questions above