SONORAN PAIN & SPINE

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HISTORY FORM

Patient Name	Date of Consultation
Age Male Female	Social Security Number
REFERRING PHYSICIAN: Full Name _____ Address _____ City _____ State/ZIP _____ Phone _____	**FAMILY PHYSICIAN:** Full Name _____ Address _____ City _____ State/ZIP _____ Phone _____

CHIEF COMPLAINT: (Explain what brought you into the office today)

_____

_____

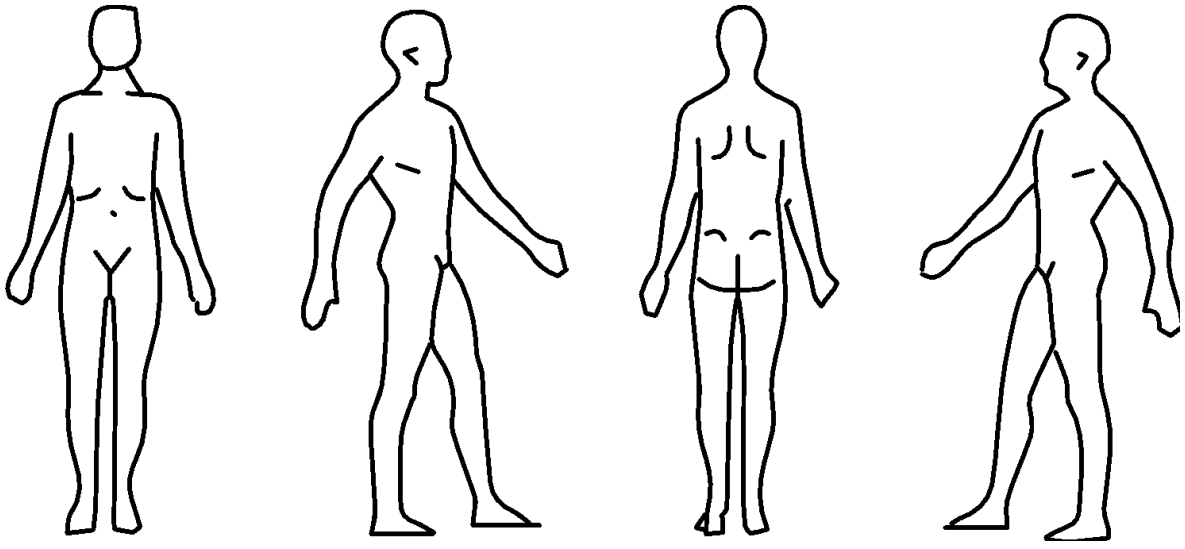
Do you have pain or another symptom?_____

A particular condition or diagnosis?_____

Did a physician ask you to come to our office for a particular type of treatment?

_____

HISTORY OF PRESENT ILLNESS: (Please indicate on the drawings below where your pain is located)



PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU ARE EXPERIENCING:

Is your problem: Constant Intermittent Frequent Occasional Infrequent

Is the pain: Sharp Dull Aching Throbbing Burning Tingling Shooting Stabbing Electrical

Is your problem: Mild Moderate Severe Excruciating

How would you rate your average pain on a scale of 0 to 10, where 0 is no pain and 10 is unbearable?_____

How long have you been experiencing this problem?_____

Please circle any of the following that make the problem worse: Time of Day Sitting Standing Bending,

Lifting Twisting Crawling Stair climbing Coughing Sneezing Heat Cold Eating Weather changes

Light Touch Stress Other: _____

Do any of the following make the problem better: Rest, heat, cold massage, medication, other: _____

Are there any factors or symptoms that occur with your problem, such as numbness, muscle weakness, bowel or bladder problems, or others?

_____

_____

What doctors have you seen for this problem? (Name and Specialty)

_____

_____

What tests have you had for this problem and what were the results, if known?

MRI _____

CT Scan _____

X-Rays _____

EMG _____

Other _____

What treatments have you had for this problem and what were the results?

Surgery _____

Physical Therapy/Occupational Therapy _____

Injection/Nerve Blocks _____

Psychological/Behavioral Pain Management _____

Osteopathic/Chiropractic Manipulation _____

REVIEW OF SYSTEMS (Please circle any of the following symptoms you are experiencing)

General:	Weight Gain/Loss Fatigue Chills Night Sweats
Skin:	Hair Changes Nail Changes Itching Rashes
Head:	Trauma Headaches
Eyes:	Vision Loss Blurriness Tearing Glasses Contact Lenses
Ears:	Hearing Loss Ringing Dizziness Earache
Mouth/Throat/Neck:	Bleeding Gums Hoarseness Sore Throat Difficulty Swallowing Swollen Neck Masses
Breasts:	Skin Changes Lumps/Masses Discharge
Respiratory:	Shortness of Breath Wheezing Productive Cough Coughing Up Blood
Cardiovascular:	Palpitations Heart Murmur Chest Pain Shortness of Breath Lying Down/ During Sleep Leg Swelling Leg Pain Leg Pain When Walking
Gastrointestinal (GI):	Loss of Appetite Nausea Vomiting Indigestions Irregular Bowel Movements Constipation Diarrhea Vomiting Blood Bloody Stools Black/Tarry Stools Hemorrhoids Abdominal Pain Jaundice
Urinary:	Frequency Urgency Hesitancy Painful Urination Blood in Urine Incontinence Stones Infections
Male:	Testicular Pain or Masses Hernias Discharge STD's Loss of Sex Interest/Function
Female:	Pregnant Irregular Periods Painful Periods Hot Flashes/Sweats STD's Loss of Sex Interest/Function
Musculoskeletal:	Joint Stiffness Joint Instability Reduced Range of Motion Swelling/Redness of Joints
Neurological:	Numbness Tingling Loss of Sensation Muscle Weakness Paralysis Tremors Seizures Fainting/Blackouts
Hematologic	Anemia Easy Bruising/Bleeding Bleeding Disorder Transfusions
Endocrine:	Heat/Cold Intolerance Excessive Sweating Excessive Thirst Excessive Hunger

PLEASE MARK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED:

☐ High Blood Pressure	☐ Diabetes	☐ Scleroderma
☐ High Cholesterol	☐ Hepatitis	☐ Carpal Tunnel Syndrome
☐ Irregular Heartbeat	☐ Pancreatitis	☐ Glaucoma
☐ Congestive Heart Failure	☐ Stomach Ulcers	☐ Strokes
☐ Coronary Artery Disease	☐ GERD	☐ TIAs
☐ Heart Attack/ MI	☐ Thyroid Disorder	☐ Seizure Disorder
☐ Peripheral Vascular Disease	☐ Kidney Disease	☐ Headaches
☐ Sleep Apnea	☐ Gynecological Problems	☐ Depression
☐ Asthma	☐ Pregnancy/LMP	☐ Anxiety/Panic Disorder
☐ Bronchitis/Emphysema/COPD	☐ Osteoarthritis	☐ Bleeding Disorder
☐ Pneumonia	☐ Rheumatoid Arthritis	☐ HIV/AIDS
☐ Tuberculosis	☐ Lupus	☐ Cancer, type
		☐ Other:

PAST SURGICAL HISTORY: (Please list all surgeries you have had and the approximate dates)

HOSPITALIZATIONS: (If you have been hospitalized, when was it and for what reason)

ACCIDENTS/INJURIES: (Please list any significant accidents or injuries and when they occurred)

MEDICATIONS: (Please list all medications you are currently taking, including aspirin)

1.	4.	7.
2.	5.	8.
3.	6.	9.

ALLERGIES: (Please list all allergies to medication, food and other items)

FAMILY HISTORY: (Please list any illnesses that are present in your family or the cause of their death)

SOCIAL HISTORY: (Please circle one)

Married Single Divorced Separated Widow/Widower

Do you live with your spouse or significant other? Yes No

How many children and grandchildren do you have? Children _____ Grandchildren _____

If you smoke, how many packs per day and for how many years? _____

How many alcoholic beverages do you drink per day? _____

Do you now or have you ever used illegal drugs? _____

Have you ever been the victim of abuse or violence? _____

What is your highest level of education? _____

Do you have vocational training and in what area? _____

OCCUPATIONAL HISTORY: (Please circle one)

Working full time Working part-time On Medical Leave Disabled Unemployed Retired

What is your current occupation? _____

Where do you work and how long have you been there? _____

FUNCTIONAL STATUS:

How long can you:

Sit _____

Stand _____

Walk _____

Climb Stairs _____

Drive _____

Does pain interfere with:

☐ Daily Activities

☐ Recreational Activities

☐ House Work

☐ Yard Work

☐ Work Duties

PATIENT GOALS: (Please list your goals for treatment)

_____

_____

_____

_____ _____

Signature Date