US Pain & Spine Institute™

Thomas L. Jones, MD

NEW PATIENT Name:_______________________________ Date of visit: ______________________

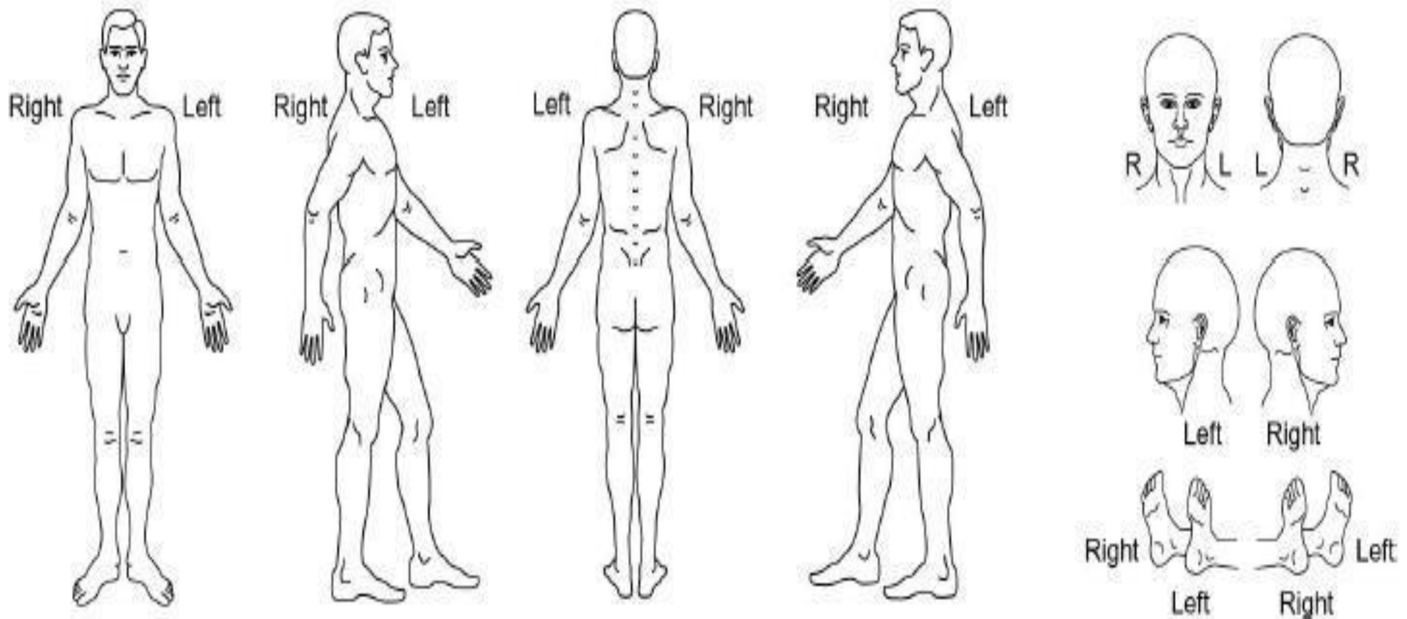
Pain/Chief Complaint: ____

How long have you had this pain? ____

Has the pain recently changed in intensity and/or character? **YES or NO** If YES, please describe:

____

Where is it located? (Please mark spot of pain with an X)



PAIN SCALE											
Over the last week, rate: (please circle answer)											
	None										Worst
Worst Pain:	0	1	2	3	4	5	6	7	8	9	10
Least Pain:	0	1	2	3	4	5	6	7	8	9	10
Usually:	0	1	2	3	4	5	6	7	8	9	10
Right Now:	0	1	2	3	4	5	6	7	8	9	10
Acceptable Level:	0	1	2	3	4	5	6	7	8	9	10

Office Use Only:

Vital Signs

Temp: _______ BP: _________SP:____

Weight: ______Height:_______

Pulse: _______

Resp: _______

Taken by: ________

What makes the pain better? (Circle all that apply)

Heat Cold Walking Sitting Standing Massage Resting in bed Medications Other: _____________________

What makes the pain worse? (Circle all that apply)

Heat Cold Walking Sitting Standing Bending down Coughing Other: ____________________________

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How would you describe your pain? (Circle all that apply)
Aching Penetrating Stabbing Tender Miserable Twisting Tiring Shooting Numb Sharp Burning Pressure
Throbbing Nagging Gnawing Unbearable Dull Tingling Shocking Other: ______________________________

What other symptoms do you have: (Circle all that apply)
Fatigue Nausea Depression Anxiety Drowsiness Difficulty Thinking Shortness of Breath Insomnia
Poor Appetite Feeling of Well-Being

How would you describe the cause of your symptoms? (Circle all that apply)
Increasing Worsening Gradually Worsening Rapidly Worsening
Decreasing Gradually Improving Without Change

Pharmacy Name: ____ **Phone:** _______________________

CURRENT MEDICATIONS:

Medications	Dose	Frequency

ALLERGY: _____________________________________
Reaction: _____________________________________

<u>Other Pain Treatments:</u> (Circle all that apply)
Physical Therapy Nerve Blocks Back Brace
Other: ____

How much pain relief have pain treatments and medicines (in total) provided for you in this past week?
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Past Medical History: (Circle all that apply) Diabetes High Blood Pressure Seizure Stroke Heart Attacks
Kidney Problems Liver Problems Bleeding Problems Cancer Infections
Other:____

Past Surgery History: (Past surgeries with dates) ____
____
____

Family History of Cancer or Painful Conditions: ____
____

Marital Status: Married Single Separated Divorced
Children (#): ____________ **Occupation:** ____

Smoking: YES or NO or Quit **Pack per day:** _______ **How long have you smoked?**_______________

Alcohol Use: Never Occasionally Frequently **Drinks per day:** ___________________________________

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History of Drug Abuse: YES or NO If yes, please elaborate: ___________________________________

Is there anything specifically that we can help you with today?

____

____

PREVIOUS TREAMENT

We need to know about the treatments you have may have already received for your current back/neck pain. If you have had a treatment below, did it make your condition better or worse?

Chiropractic Care	☐ Better	☐ Worse
Physical Therapy	☐ Better	☐ Worse
Injections	☐ Better	☐ Worse
Psychological Consultation	☐ Better	☐ Worse

Other ____

For your current back/neck pain, please mark the boxes for the timeframe in which any tests were done.

	< 6 months	**< 12 months**
X-rays	☐	☐
MRI scan	☐	☐
CT scan	☐	☐
Myelograms	☐	☐
Discogram	☐	☐
EMG/NCV (nerve test)	☐	☐

Have you ever had surgery on your back or neck? YES NO

IF YES, please complete the following:

1) Type of Surgery____ Surgeon_______________________

Did it make your pain: ☐BETTER ☐WORSE

2) Type of Surgery____ Surgeon_______________________

Did it make your pain: ☐BETTER ☐WORSE

3) Type of Surgery____ Surgeon_______________________

Did it make your pain: ☐BETTER ☐WORSE

Do you have any of the following problems?

Is your pain worse at night?	☐ YES	☐ NO
Does your pain awaken you from sleep?	☐ YES	☐ NO
Does coughing affect your pain?	☐ YES	☐ NO
Do your legs tire or hurt if you walk too far?	☐ YES	☐ NO

If YES, how far can you walk? _______________________________

Is this relieved by resting your legs?	☐ YES	☐ NO
Is this relieved by bending forward?	☐ YES	☐ NO

Bladder Control: ☐ No Problem ☐ Can't Empty Bladder ☐ Loss of Control (Accidents)

Bowel Control: ☐ No Problem ☐ Constipation ☐ Loss of Control (Accidents)