**INTAKE FORM**

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list names of other healthcare professionals that have been involved in the management of your pain:**

*Pain Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spine(orthopedic or neuro) Surgeon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physical therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

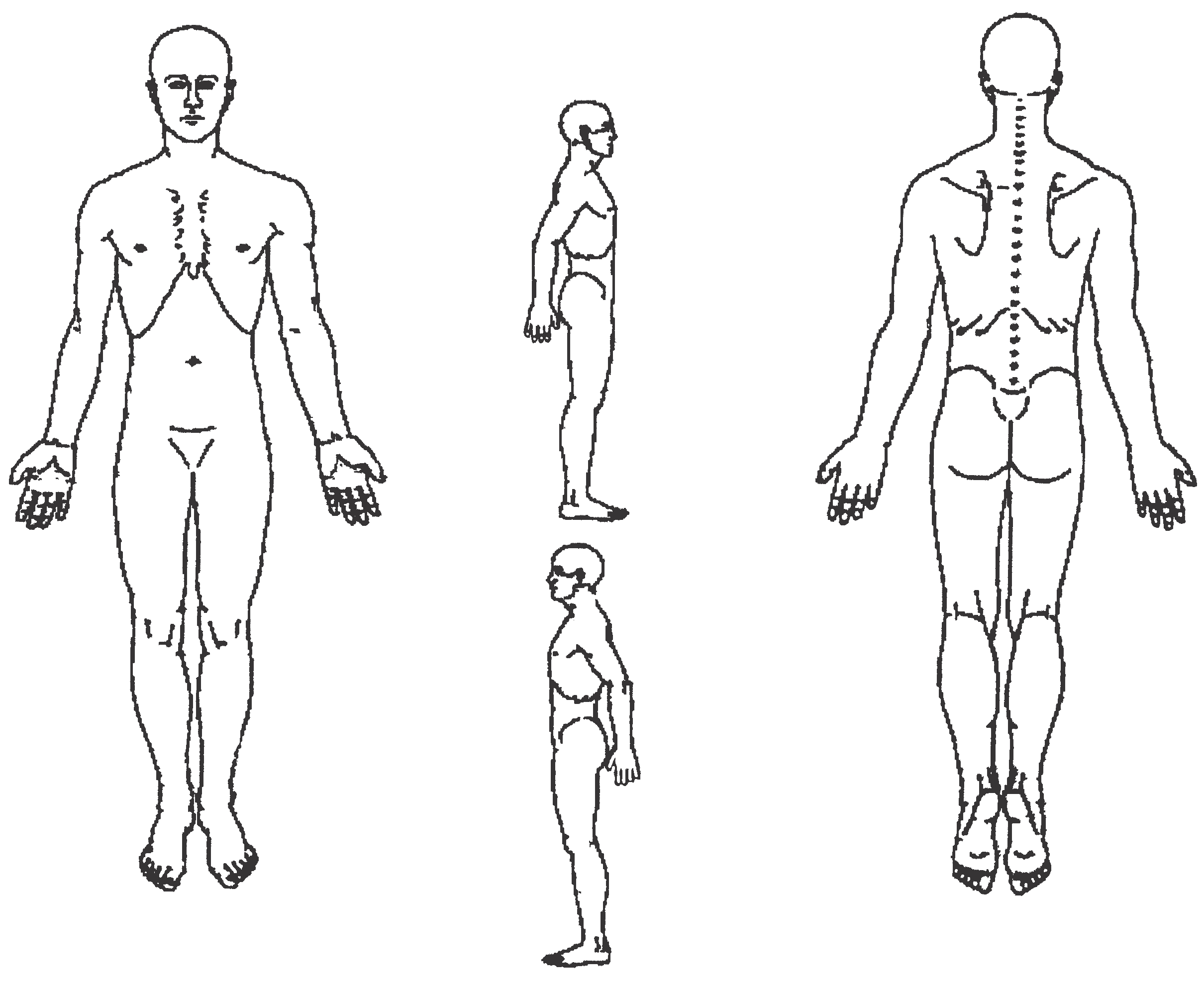
*Neurologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**PAIN HISTORY**

**PLEASE DESCRIBE YOUR PAIN PROBLEM – Mark where your pain located – including any spreading/radiation – please state R for right, L for left or B for both if both sides are involved.**

*Head\_\_\_\_\_ Forehead\_\_\_\_\_\_Back of the head\_\_\_\_Eye\_\_\_\_\_\_Face\_\_\_\_\_\_\_Neck\_\_\_\_\_\_Shoulder\_\_\_\_\_\_\_\_Between Shoulder blades\_\_\_\_\_ \_\_\_\_\_Elbow\_\_\_\_\_ Hand\_\_\_\_\_Upper back\_\_\_\_Chest wall\_\_\_\_\_Flank\_\_\_\_\_\_Abdomen\_\_\_\_\_ Pelvis\_\_\_\_\_\_Groin\_\_\_\_\_\_Genitals\_\_\_\_\_\_\_Lower back \_\_\_\_\_ Buttocks\_\_\_\_Thighs\_\_\_\_\_ Knee\_\_\_\_\_\_\_Calf \_\_\_ \_\_ Foot\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Please use the diagram below to demonstrate where your pain is located by shading the painful areas:

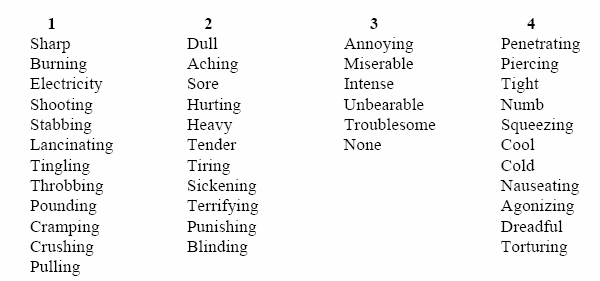


* **WHEN did your pain first begin? (number of months/years or calendar year) \_\_\_\_\_\_\_\_\_\_**
* **HOW did your pain begin? (Please choose one option)**

*No triggering event – pain started spontaneously\_\_\_\_\_\_\_\_\_ After an accident\_\_\_\_\_\_Date of accident\_\_\_\_\_\_ Work related?\_Yes N0\_ Pending litigation? Yes N0\_\_ After surgery\_\_\_\_\_\_\_*

*Date of Surgery\_\_\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

* **WHAT DOES YOUR PAIN FEEL LIKE? Please circle any of the words below which describes the character of your pain:**



* **HOW DOES YOUR PAIN CHANGE WITH TIME? Please circle any of the words below that describe the pattern of you pain:**

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* **What makes your pain WORSE?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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* **Which makes your pain BETTER? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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* **How does pain affect your lifestyle? (What can you no longer do because of your**

**pain condition?)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAST MEDICAL HISTORY**

*DIABETES HTN CARDIAC DISEASE PREVIOUS HEART ATTACK CONGESTIVE HEART FAILURE*

*COPD ASTHMA OTHER LUNG DISEASE GERD STOMACH ULCERS HEPATITIS CIRRHOSIS PANCREATIC DISEASE KIDNEY DISEASE STROKE SEIZURES CANCER*

OTHER PROBLEMS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGICAL HISTORY**

**Please list any operation(s) or surgeries you have had in the past:**

* Type of surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year \_\_\_\_\_\_ Type of surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Year \_\_\_\_\_\_\_\_
* Type of surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year \_\_\_\_\_\_ Type of surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Year \_\_\_\_\_\_\_\_
* Type of surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year \_\_\_\_\_\_ Type of surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Year \_\_\_\_\_\_\_\_
* Type of surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year \_\_\_\_\_\_ Type of surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Year \_\_\_\_\_\_\_\_

**FAMILY HISTORY**

**Please list any medical conditions that run in your family including chronic pain, substance use or back/neck surgeries – specify how they are related to you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**ALLERGIES:**

* **Please list your ALLERGIES TO MEDICATIONS or OTHER DRUGS:**

Name of Medication Adverse Reaction Experienced When was the last time this happened?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Are you allergic to Iodine Contrast Dye (e.g. IVP Dye)?** \_\_Yes \_\_No

If you answered yes, what type of reaction did you have and when?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Are you allergic to Aspirin or Anti-Inflammatory Medications (e.g. Ibuprofen)?**

\_\_Yes \_\_No If you answered yes, what type of reaction did you have?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS:**

* Bring all current medications including prescription bottles to office visit

**Please list the medications which you currently take FOR PAIN:**

Name of Pain Medication Dosage How Often do you take? Who prescribed it for you?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list the medications (names and doses) which you currently take FOR OTHER MEDICAL CONDITIONS:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please review and mark **ALL** items that have applied to you **within the last month** (including today)

***GENERAL HEALTH:*** *None Weight loss Weight gain Fatigue Loss of appetite*

***Females:*** *Pregnant*

***EYES:*** *None Eye pain Double vision Severe Redness Loss of vision*

***EARS:*** *None Ear pain Hearing loss Ringing in ears Dizziness*

***NOSE:*** *None Runny nose Nasal congestion Nosebleeds Sinus pain/pressure*

***MOUTH/THROAT:*** *None Sore throat Problems Swallowing Sores in mouth Tooth pain Hoarseness*

***CHEST/HEART:*** *None Chest pain Racing/pounding heart Leg pain/limp w/walking*

*Problems breathing w/ lying down*

***RESPIRATORY:*** *None Cough Wheezing Shortness of breath Coughing up blood or mucus w/ blood*

***STOMACH:*** *None Heartburn Nausea/vomiting Abdominal pain Vomiting up blood*

***BOWELS:*** *None Diarrhea Constipation Black/bloody stools Unusual change in stool size/shape/color*

***URINARY TRACT:*** *None Blood in urine Increased urination Difficulty urinating Pain w/urination*

***MUSC/SKEL:*** *None Back pain Pain in muscles/joints Limited range of motion in joints*

***SKIN:*** *None Rash Redness Sores Changing moles/warts or other lesions*

***NEUROLOGICAL :*** *None Seizures Problems w/coordination Memory/Sensory issues Weakness/numbness/tingling*

***ENDOCRINE:*** *None Unusual changes w/ skin or hair Increased sensitivity to temperature changes*

***BLOOD:*** *None Bleeding gums Frequent nosebleeds Swollen hands/feet Swollen glands*

*Unusual bruising*

***IMMUNE:*** *None Sneezing Itchy eyes Frequent sinus/ear or respiratory infections*

***MENTAL HEALTH:*** *None Mood swings Emotional changes Anxiety/Depression*

*Thoughts of hurting self or others*

* **Do you take Aspirin?** \_\_ Yes \_\_ No **If you answered yes, when was your last dose?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Do you take Coumadin, Plavix, Pletal, Aggrenox, or Ticlid?** \_\_ Yes \_\_ No

**If you answered yes, when was your last dose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you answered yes, will the prescribing physician allow you to discontinue this blood thinner medication for any length of time? \_\_\_ Yes\*\* \_\_\_ No**

\*\* Please note that you MUST have permission from the physician who prescribes or manages the blood thinner in order to stop this medication.

* **Do you take any herbal medications?**\_\_ Yes \_\_ No **If yes, list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Do you take Vitamin E? \_\_\_ Yes \_\_\_ No**

**SOCIAL HISTORY**

* **What is your current marital status? (Please check one) How Long?**

*\_\_ Single- Never Married \_\_ Married \_\_\_\_\_\_\_\_\_\_ years \_\_ Divorced \_\_\_\_\_\_\_\_\_\_ years*

*\_\_ Widowed \_\_\_\_\_\_\_\_\_\_ years \_\_ Separated \_\_\_\_\_\_\_\_\_\_ years*

* **With whom do you live? (Check all that apply)**

*\_\_ I Live Alone \_\_ With My Parents \_\_ With Spouse \_\_ With In-Laws*

*\_\_ With Children (ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) \_\_ With Other Relatives \_\_ With Siblings*

*\_\_ With Others (Significant Other, friends, Roommate, etc.)*

* Do any of them have alcohol or drug problems?\_\_\_\_Yes \_\_\_\_No
* **How far did you get in school? (Please check one)**

*\_\_ Less than 8th grade \_\_ Completed College\_\_ Completed 8th grade\_\_ Technical or Business School*

*\_\_ Completed High School \_\_ Advanced Degree (Type \_\_\_\_\_\_\_\_ ) \_\_ Some College ( \_\_\_ years)*

* **Do you currently smoke cigarettes?** \_\_ Yes \_\_ No

**If yes, how many packs do you smoke during an average day?** \_\_\_\_\_ packs /day **If yes, for how many years have you smoked?** \_\_\_\_ years

**If no and you are a former smoker, when did you quit for good?** \_\_\_\_\_\_\_\_\_\_\_\_\_

* **Do you drink alcoholic beverages?** \_\_\_ Yes \_\_\_ No **If yes, how often?**

*\_\_ Daily or More Often\_\_ Less Than Once A Week \_\_ Several Times A Week \_\_ About Once A Week*

*\_\_ I am a heavy drinker*

* **How many drinks do you have each time you consume alcohol?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Have you ever been diagnosed with or treated for drug or alcohol abuse?**

\_\_ Yes \_\_ No

**If yes, when?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Please describe \_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Have you ever used illicit drugs.** \_\_\_ Yes, \_\_\_ No. Do you currently use **illicit drugs.** \_\_\_ Yes, \_\_\_ No.

W**hat drug\_\_\_\_\_\_\_\_\_\_ last time used**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **What do you do for exercise and how often?**

*\_\_\_Nothing \_\_\_\_Walking \_\_\_Jogging \_\_\_Spinning \_\_\_Biking Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_Once a month \_\_\_Once a week \_\_\_Twice a week \_\_\_\_Thrice a week \_\_\_Daily*

**WORK HISTORY**

* **What is your employment status? (please check one)**

*\_\_ Retired \_ Able to work but currently unemployed \_\_ Homemaker \_\_ Student*

*\_\_ Not working, on Workers’ Comp. leave from my job since \_\_\_\_\_\_\_\_\_\_\_ Working Full Time ( \_\_\_ Light Duty )*

*\_\_ Not working, on Disability since (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Working Part Time*

* **What is (was) your occupation or job title? (please describe)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Which of the following are regular requirements of your job? (Check all that**

**apply to you)**

*\_\_ Heavy Lifting (over 30 pounds) \_\_ Light Lifting (15 - 30 pounds)*

*\_\_ Frequent Stooping, Bending, Twisting\_\_ Standing For Long Periods of Time (over one hour at a time)*

*\_\_ Sitting For Long Periods of Time (over one hour at a time) \_\_ Computer Work*

*\_\_ Other Physical Requirements (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

* **How much work have you missed as a result of your pain problem? (check one)**

\_\_ None

*\_\_ I have missed \_\_\_\_ days of work due to my pain problem*

*\_\_ I have missed \_\_\_\_ weeks of work due to my pain problem*

*\_\_ I have missed \_\_\_\_ months of work due to my pain problem*

*\_\_ Not applicable to my situation \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

* **Please use the following space to describe any other issues related to your pain condition that has not been covered in the above questions. Your comments and concerns are welcome:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**WHICH DIAGNOSTIC STUDIES HAVE BEEN DONE TO EVALUATE YOUR PAIN PROBLEM?**

* If you have had any of the imaging done please bring copies of the reports or films including EMG/NCS, MRI, CT-scan, or X-rays to office visit **(Please check all that apply)**

Ordered by Whom?

*\_\_ Blood Tests \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X-Rays \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_ MRI Scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CT scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_ EMG / Nerve Conduction Studies \_\_\_\_\_\_\_\_ Bone Scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_ other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**WHICH TREATMENTS HAVE BEEN DONE FOR YOUR PAIN PROBLEM?**

*Injection Treatments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Chiropractor Treatments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Acupuncture\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Surgical Treatments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Physical Therapy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Psychological Treatments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**I certify that I have answered all of the above questions truthfully and to the best of**

**my ability**

Patient Name (Pls. Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_