

6) **When is your pain the best?** AM Afternoon Night
When is your pain the worst? AM Afternoon Night

7) **Circle which factors make your pain better**
Sitting Standing Walking Bending Lying down Driving Coughing/sneezing

8) **Circle which factors make your pain worse**
Sitting Standing Walking Bending Lying down Driving Coughing/sneezing

9) **List other Doctors who have treated you for this problem:**

10) **List tests that have been performed (i.e. MRI, CAT scan, myelogram, etc):**

11) **Circle any treatments you have tried before to treat your pain:**

Physical Therapy Chiropractor Massage Therapy Ice Heat TENS Unit Other

12) **Have you previously had any injections/epidurals for your pain?**

13) **Have you been treated by other pain specialists/clinics in the past?**

14) **List all pain medications you have tried in the past that did not relieve your pain or caused bad side effects:**

15) **Please answer the following questions if your problem is the result of an injury:**

Mark only one:

- I never had back/neck problems before this injury.
- I had back/neck problems before, and this injury made the problem worse.

Mark all that apply:

- This injury occurred at work.
- My injury did not occur at work.
- I have filed a claim through worker's compensation
- I have pursued or will pursue legal action as result of this injury.

Current Medications

List all your medications, dosages and how often you take them every day

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Are you taking any blood thinners? Yes No

Past Medical History

Do you have any of the following conditions?

- | | | | | | |
|-----------------------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|
| Any contagious disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bleeding problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suppressed immune system | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart disease or chest pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lung disease (asthma/COPD) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stomach ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seizure Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Liver disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If any of the above yes, or if you have any other medical problems, please explain:

Previous Surgeries

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Family History

(Your blood relatives)

- 1. Cancer
- 2. Chronic Pain
- 3. Other

Drug Allergies

- A _____
- B _____
- C _____
- D _____
- E _____

