RPK Center for Rehab, Spine and Pain Management

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_**

**MOS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years in Service: \_\_\_\_\_\_\_\_\_\_\_\_\_ Jump Status: YES / NO**

**PAIN HISTORY – NECK PAIN**

**Where is your pain most severe (scalp, neck, arms)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What percent is in each area (total 100%)?**

**Head / Neck \_\_\_\_\_\_\_\_\_\_\_\_\_ Right Arm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Left Arm \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Origin of neck pain (training, auto accident, repetitive trauma)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe your pain (circle all that apply)?**

 **Sharp / Stabbing Dull / Aching Shooting / Shocking**

**When is your pain worse?**

 **Daytime / Nighttime Activity / Rest**

**What makes your pain better?**

 **Rest or Activity Leaning head forward or sideways**

**What medications have been used for this condition (name and dose, continue on other side if needed)?**

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

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

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

**What treatments have you had (enter date of last treatment)?**

 **Acupuncture \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chiropractic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **TENS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Counseling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Traction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Have you had surgery for this condition? YES / NO (If yes, list date and procedure(s) performed)**

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

**Have you had spinal injections for this condition? YES / NO (If yes, list date and procedure(s) performed)**

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

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

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

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

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

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**PAST MEDICAL HISTORY** (Circle all that apply - current or past illnesses):

Neck pain

Back pain

Arthritis

Migraines

Heart disease

Lung disease

Arthritis

Diabetes

Alcohol Abuse

Illicit Drug Abuse

Prescription Drug Abuse

**PAST SURGICAL HISTORY** (Circle any surgeries you have had – please add date of surgery):

Back surgery

Neck surgery

Shoulder surgery

Elbow surgery

Wrist / Hand surgery

Hip surgery

Knee surgery

Ankle / Foot surgery

**REVIEW OF SYSTEMS**:

Constitutional fevers, chills, fatigue

Musculoskeletal neck pain, back pain, joint pain, joint swelling, muscle cramps/spasms, morning stiffness

Neurologic weakness, numbness, seizures, headache

Psychiatric depression, anxiety, suicidal ideation, sleep problems

Eyes, Ears eye pain, ear pain, tinnitus

 Nose, Throat nosebleeds, swallowing difficulty

Cardiovascular chest pain, palpitations

Respiratory shortness of breath

Gastrointestinal abdominal pain, nausea, diarrhea, constipation

Genitourinary dysuria, hematuria

Hematologic anticoagulant medications

Allergy/Immunology drug allergies, HIV exposure, hepatitis exposure

|  |  |  |  |
| --- | --- | --- | --- |
| Current Medications(Brand or Generic Name) | Dose | Frequency(How often you take it) | Reason for use  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**DRUG ALLERGIES** (List all medication allergies):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_

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**ORT QUESTIONNAIRE:**

 Your Age \_\_\_\_\_\_\_\_

 Family History of Abuse Alcohol YES NO

 Illegal Drugs YES NO

 Prescription Drugs YES NO

 Personal History of Abuse Alcohol YES NO

 Illegal Drugs YES NO

 Prescription Drugs YES NO

 Personal History of Sexual Abuse (female only) YES NO

 Mental Health Depression YES NO

 ADD / ADHD / OCD YES NO

 Bipolar / Schizophrenia YES NO

**SOCIAL HISTORY**:

Smoking status:

Current Former (year quit \_\_\_\_\_) Never

Alcohol use: usual beverage -- beer / wine / liquor

 Daily

Frequent (4 or more times per week)

Occasional (up to 3 times per week)

Infrequent (less than 1 drink per week)

Rare (less than 1 drink per month)

None

Illicit drug use (circle on entry on 1st line; circle any drugs ever used):

Current Former (last use \_\_\_\_\_\_\_\_\_) Never

 Marijuana Heroin Opioids (overuse or abuse)

Cocaine Crack Methamphetamine

**FAMILY HISTORY:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Mother | Father | Brothers | Sisters |
| Heart Disease |  |  |  |  |
| Diabetes |  |  |  |  |
| Cancer |  |  |  |  |
| Depression / Anxiety |  |  |  |  |
| Substance Abuse |  |  |  |  |

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**Please use A (aching) B (burning) N (numbness) P (pins and needles) S (stabbing) to draw your pain:**

