RPK Center for Rehab, Spine and Pain Management

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

Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAIN HISTORY**

Where is your pain?

When did the pain start?

How did the pain start (Car accident, trauma, no apparent reason)?

Have you ever been seen by another pain clinic? YES NO

 If yes, who was the provider and when were you last seen?

Which of the following describes your pain (circle all that apply)?

 Burning Stabbing Sharp Aching

Shooting Shocking Dull Throbbing

Which of the following make you feel better?

 Sitting Lying down Stretching Heat

 Ice Medications Rest NONE

Which of the following make you feel worse?

 Standing Walking Sitting Lifting

 Exercising Heat Ice NONE

Does your pain cause emotional distress? YES NO

Does your pain affect any of these activities (circle all that are affected)?

 Work Leisure Sports NONE

 Self-care Child care Sleep

Which of the following treatments you have had for this pain (circle all that apply)?

 Medications Therapy TENS Back brace

Acupuncture Chiropractor Meditation Counseling

Injections Surgery

RPK Center for Rehab, Spine and Pain Management

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

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

Chronic pain

Neck pain

Back pain

Arthritis

CAD

Hypertension

Dyslipidemia

Atrial Fibrillation

Stroke

Migraine

Multiple Sclerosis

Seizures

COPD

Asthma

Sleep Apnea

Pancreatitis

GERD

Ulcer disease

Liver disease

Kidney disease

Thyroid disease

Diabetes

Cancer

DVT

Vascular disease

Anxiety

Depression

Bipolar

Schizophrenia

Alcohol Abuse

Illicit Drug Abuse

Prescription Drug Abuse

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

Back surgery Tonsillectomy Hernia

Neck surgery Cholecystectomy Cataract

Shoulder surgery Appendectomy Hemorrhoidectomy

Elbow surgery Hysterectomy Cesarean

Wrist / Hand surgery Carotid endarterectomy Prostatectomy

Hip surgery CABG Mastectomy

Knee surgery Cardiac stent

Ankle / Foot surgery Vascular stent

**REVIEW OF SYSTEMS**:

Constitutional generalized pain, fevers, chills, fatigue, poor energy

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

Neurologic weakness, numbness, seizures, tremors, headache

Psychiatric depression, anxiety, memory loss, suicidal ideation, sleep problems

Eyes, Ears eye pain, glasses, photophobia, ear pain, hearing aid, tinnitus

 Nose, Throat nosebleeds, hoarseness, swallowing difficulty

Cardiovascular chest pain, palpitations, syncope, limb swelling

Respiratory chronic cough, wheezing, shortness of breath

Gastrointestinal abdominal pain, nausea, diarrhea, constipation, jaundice

Genitourinary dysuria, hematuria, incontinence, sexual dysfunction

Hematologic abnormal bleeding/bruising, anticoagulant medications, enlarged lymph nodes

Allergy/Immunology seasonal allergies, drug allergies, chronic infection, HIV exposure, hepatitis exposure

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

RPK Center for Rehab, Spine and Pain Management

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

|  |  |  |  |
| --- | --- | --- | --- |
| Medication(Brand and Generic Name) | Dose | Frequency(How often you take it) | Reason for use  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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

Please keep a copy of this list and update it after each visit.