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Physical Medicine and Rehabilitation

 Pain Management

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 Medical Information about your problem for the doctor

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the primary problem that brought you to this office? (5 words or less) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the second biggest problem facing you right now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your age: \_\_\_\_\_\_ Was this an injury at work? \_\_\_\_\_ YES \_\_\_\_\_ NO

Date of injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the date you last worked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the injury or problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What doctors have you seen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What was their diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What special studies have you had done? (for example: CT Scans, MRI’s, etc…) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If you have pain, what makes the pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have pain, what makes the pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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On the drawing below, please use the legend to note the kind of pain and draw on the figure the area of your problem:

**(A)** Aching **(N)** Numbness **(P)** Pins and Needles **(B)** Burning **(S)** Stabbing



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Have you had physical therapy in the past? If so for how long? Last time you had it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did it cause a permanent improvement? \_\_\_\_\_\_\_\_

Temporary improvement?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Make you worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past medical history: Please list all medical or surgical problems you have had in the past:

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

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Please list all medications that you are taking NOW, including dose and frequency:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 11. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 12. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 For office use only below

|  |  |  |
| --- | --- | --- |
| ROS: Nl  | Abnl |  Findings  |
| gen: |  |  |
| CV |  |  |
| HEENT |  |  |
| Eye |  |  |
| GI |  |  |
| Heme |  |  |
| MS |  |  |
| Neuro |  |  |
| Psych |  |  |
| Resp |  |  |
| Skin |  |  |
| Gu |  |  |

List all drug allergies:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review of symptoms: Do you have any other symptoms than those previously mentioned? (sleep, etc…)

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

After you turn off the lights, TV and put your head on the pillow, how long does it take to FALL asleep? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How many times a night do you awaken? \_\_\_\_\_\_\_\_\_\_\_\_ How long does it take you to return to sleep?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family history: Have any of your family members had similar problems?

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

What medical problems did your mother have? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Your father?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

We apologize for the following questions, but insurance companies request that we ask the following questions:

Do you or have you ever used street drugs? YES \_\_\_\_\_ NO \_\_\_\_\_

Have you ever abused narcotics? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you smoke or did you ever smoke? YES \_\_\_\_\_ NO \_\_\_\_\_

How many years? \_\_\_\_\_ How many packs per day? \_\_\_\_\_

Social history: What was your line of work? (please describe what you did during the day)

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

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Who lives at home with you?

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Has this problem caused a problem between you and your spouse?

YES \_\_\_\_\_ NO \_\_\_\_\_

How are you supporting yourself at this point?

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

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Are you currently getting Worker’s Compensation checks?

YES \_\_\_\_\_ NO \_\_\_\_\_

Do you have a lawsuit in progress or have you talked to an attorney?

YES \_\_\_\_\_ NO \_\_\_\_\_

***For office use only: (Do not write below this line)***

height\_\_\_\_\_\_\_\_\_ weight\_\_\_\_\_\_ pain level today\_\_\_\_\_\_\_ pulse\_\_\_\_\_\_\_\_\_\_

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

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| PE: |  NI  |  Abnl  |  Findings |
| cons. |  |  |  |
| eyes |  |  |  |
| ent |  |  |  |
| neck |  |  |  |
| resp |  |  |  |
| CV |  |  |  |
| chest |  |  |  |
| Abd |  |  |  |
| Gu |  |  |  |
| MS |  |  |  |
| skin |  |  |  |
| neuro |  |  |  |
| psych |  |  |  |

 (03/08/2018)