

Patient Name: _____

Male/Female Age: _____ years Height: _____ ft _____ in Weight: _____ lbs

Please List Any/All Allergies _____

What is the main problem for which you are seeking treatment? _____

When your current pain started, was there a precipitating event? (*circle one*):

Automobile accident Work Injury Surgery Sports Other _____

How long have you had your current pain problem? _____ years, _____ months

Describe what the pain feels like: _____

How do the following affect your pain? (Please check one for each item.)

Lying down:	_____ Decrease	_____ No Effect	_____ Increase
Standing	_____ Decrease	_____ No Effect	_____ Increase
Sitting	_____ Decrease	_____ No Effect	_____ Increase
Walking	_____ Decrease	_____ No Effect	_____ Increase
Exercise (if applicable)	_____ Decrease	_____ No Effect	_____ Increase
Medication	_____ Decrease	_____ No Effect	_____ Increase

Are there other factors that make your pain...

Better? (please list) _____

Worse? (please list) _____

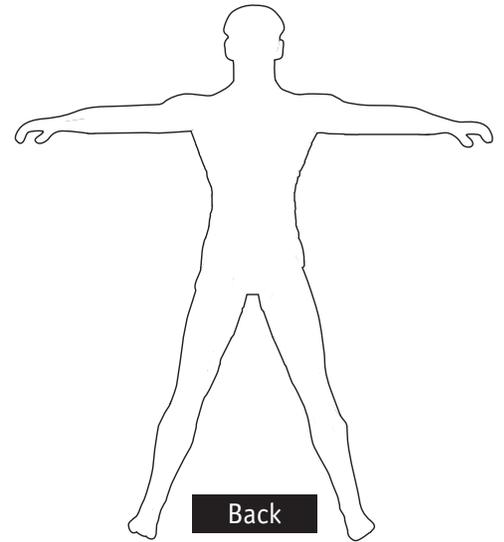
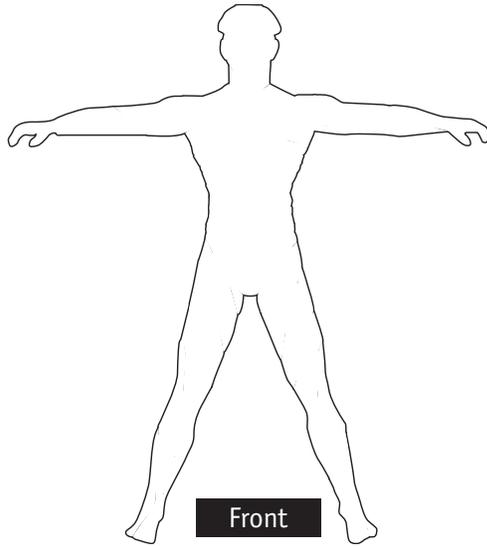
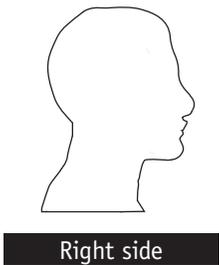
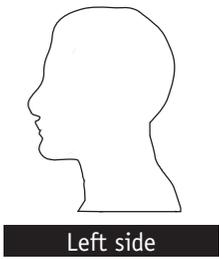
Please rate your pain intensity on a scale from 0 = no pain to 10 = excruciating, incapacitating worst pain possible. Write the number (from 0-10) in the spaces below:

- Your pain at its worst in the past month or since your injury _____
- Your pain at its least in the past month or since your injury _____
- Your current pain _____

How often do you have your pain? (please check one below)

- ___ Constantly (100% of the time)
- ___ Nearly constantly (60% to 95% of the time)
- ___ Intermittently (30% to 60% of the time)
- ___ Occasionally (less than 30% of the time)

Below - please indicate the location of pain.



Circle the number that best describes your pain now.
0 = No Pain; 10 = Worst Imaginable Pain

0	1	2	3	4	5	6	7	8	9	10
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C O N F I D E N T I A L
for evaluation and treatment purposes ONLY!

Coping Information

Have you ever experienced any physical, emotional or sexual abuse? Yes No

If yes, explain: _____

Have you ever had psychiatric, psychological, or social work evaluations for any problem, including your current pain? Yes No

If yes, what and when? _____

Have you ever been in treatment for misuse of alcohol, illicit drugs or prescribed medications? Yes No

If yes, where and when? Location: _____ Date: _____

Medication List

Name of Medication and Dosage	Date first prescribed	Daily amount taken	Reason for medication	Physician Name	Did this help with your pain? (Put an "x" by all that helped)

Please circle all of the treatments you have tried (or are currently using) for your pain.

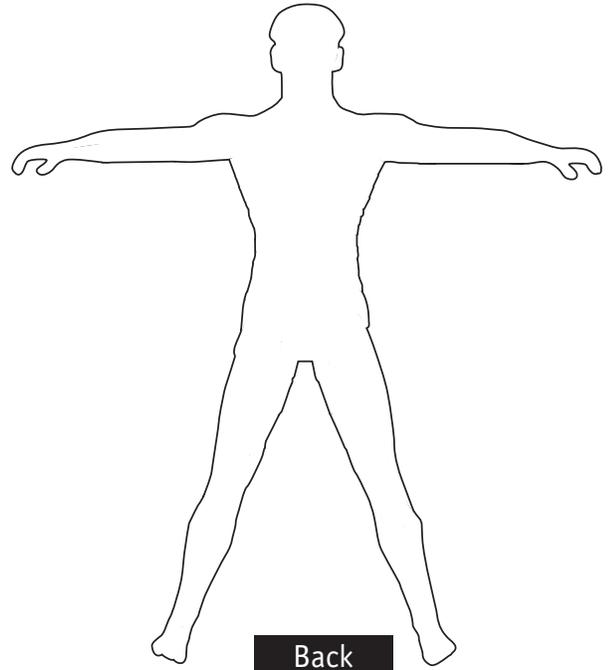
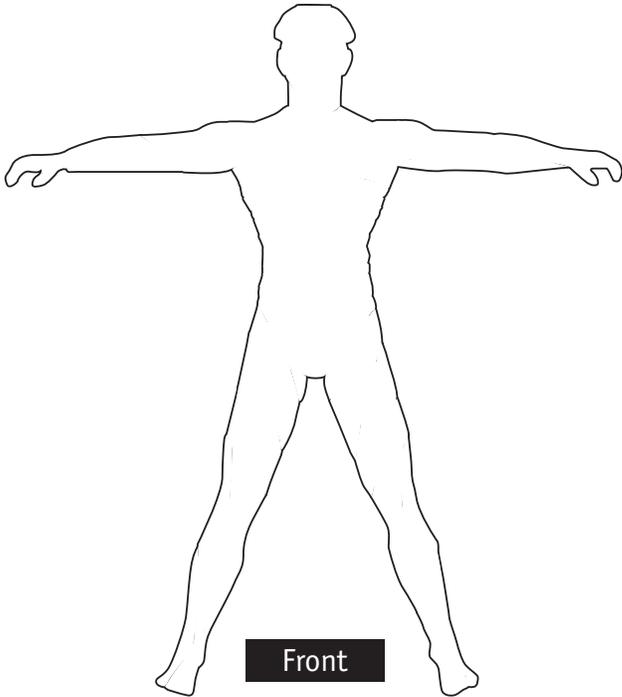
Physical Therapy	Biofeedback
Acupuncture	Hypnosis
Massage Therapy	Nerve Block
TENS Unit	Trigger Point Injections
<i>(Transcutaneous Electrical Nerve Stimulation)</i>	Rehabilitation
Chiropractor	Radio Frequency Lesioning
Surgery	Nutritional Supplements
Spinal Cord Stimulator	Dietary Changes
Cognitive Behavior Therapy	
Other: _____	

Initial Consultation Form

Date _____

Patient Name _____

Below - please shade in the areas of pain.



Circle the number that best describes your pain now.

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0	1	2	3	4	5	6	7	8	9	10
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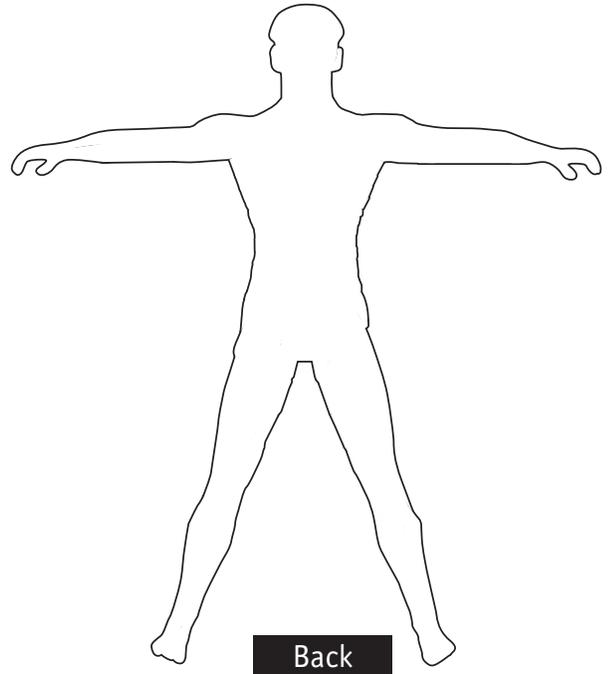
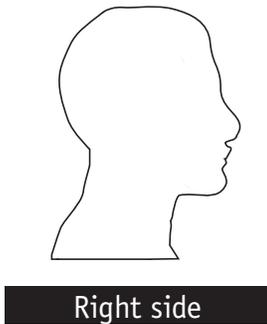
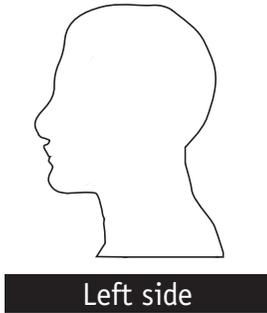
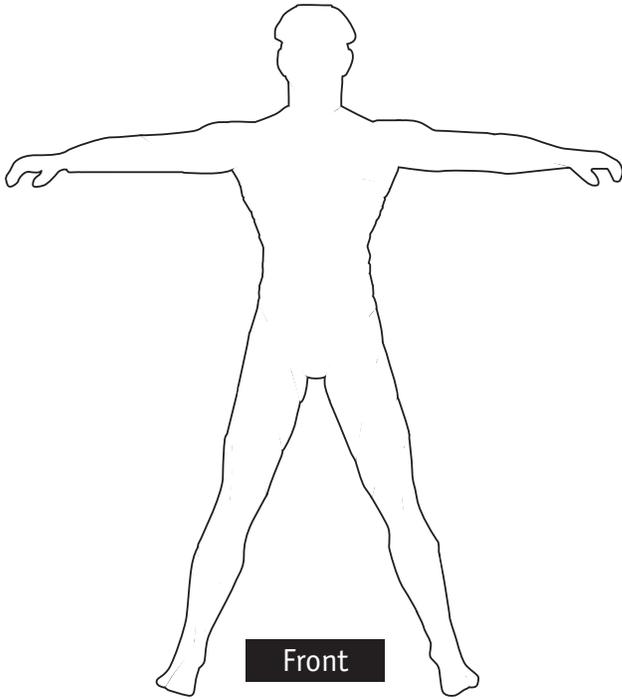
Therapy Instructions/Adjustments _____

Patient Re-Evaluation Form

Date _____

Patient Name _____

Below - please shade in the areas of pain.



Circle the number that best describes your pain now.

0 = No Pain; 10 = Worst Imaginable Pain

0	1	2	3	4	5	6	7	8	9	10
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Therapy Instructions/Adjustments _____
