NAME_____ ____
ADDRESS _____
PHONE_____
AGE___ DOB___/___/___ HT___ WT___
RACE_____MALE_____ FEMALE
SSN_____
DATE OF ACCIDENT: _____/___/____

REFERRED BY_____
DATE OF VISIT_____

CIRCLE APPROPRIATE ANSWERS OR EXPLAIN:

1. TYPE OF INJURY AUTO___ WORK__ OTHER___

PLEASE GIVE DETAILED EXPLANATION OF INJURY OR ACCIDENT. WAS IT A TWIST, LIFTING, OR A FALL? HOW FAR DID YOU FALL?

GIVE HISTORY OF HOW THE PAIN STARTED EVEN IF NOT RELATED TO TRAUMA

_____

_____

_____

_____

WHAT PART OF YOUR BODY WAS HURT?

DID YOU LAND ON YOUR HANDS? _____

(AUTO ONLY) SEATBELT ON? YES __ NO__
TYPE OF COLLISSION: FRONTEND___ REAR END___BROADSIDE___ DRIVER___ PASSENGER___

HANDS ON STEERING WHEELS? YES__ NO __ HANDS HIT THE DASH BOARD? YES___ NO ___
WHAT DID YOU STRIKE WITHIN THE CAR? _____

WHAT PART OF THE BODY?_____ ANY FRACTURES, LACERATIONS_____

2. (EXPLAIN) RECENT HISTORY
A. DATE OF ONSET _____ GRADUAL_____ SUDDEN_____

B. USE PAIN DIAGRAM ALSO (SEE PAGE 6)
PAIN: NECK. MID BACK, LOW BACK, EXTREMITIES, WHAT JOINTS _____R_____ L _____
PAIN DESCRIPTION: SHARP, STABBING, SHOOTING, BURNING, ACHING, OR _____

PAINFUL SIDE: RIGHT, LEFT, CENTRAL, RIGHT MORE, LEFT MORE, EQUAL ON BOTH SIDES, OTHERS
DAILY PAIN: _____ HRS_____ MIN _____ TIMES _____DAYS, WEEK, MONTH

3. NUMBNESS ARM. FOREARM. WRIST, HAND (PALM, BACK)
FINGERS (THUMB, INDEX, M,D, RING, LITTLE) WHAT OTHER JOINTS_____R_____ L_____
THIGH. LEG, FOOT (TOP SOLE), TOES (BIG, 2, 3. 4, LITTLE) JOINTS_____R_____ L _____

4. WEAKNESS: EXTREMITIES (ANYSTIFFNESS, CRAMPS. KNEES BUCKLING, FALLING) DROPPING OBJECTS FROM HANDS? YES——— NO ——— (RIGHT. LEFT, BOTH; FREQUENT, OCCASIONAL).

5. DID YOU GO TO THE EMERGENCY ROOM? YES__ NO___ WHEN _____
WHAT TESTS DID THEY PERFORM? _____
WHAT TREATMENT DID YOU RECEIVE? _____

6. HAVE SYMPTOMS GOTTEN WORSE IN THE PAST: 1, 3, 6, 8, 12 MONTHS OR MORE? YES___ NO__

7. WHICH SYMPTOMS BOTHER YOU THE MOST? PAIN. WEAKNESS. NUMBNESS?

8. WHICH AREA BOTHERS YOU THE MOST? NECK, MID-BACK, LOW-BACK, ARM, FOREARM, WRIST, FINGERS

9. HOW LONG HAVE YOU BEEN DISABLED BY PAIN? _____

10. DO YOU OCCASIONALLY NEED TO STOP ACTIVITIES DUE TO PAIN? YES_____ NO_____
IF YES, WHAT ACTIVITIES_____

11. HOW LONG CAN YOU SIT?_____ STAND? ____ WALK? _____ (HRS ___ OR MINUTES)_____.

12. DO YOU HAVE TO USE CANES, CRUTCHES, WHEELCHAIR, RAILING TO CLIMB STAIRS? YES___ NO____
IFYES, WHICH DO YOU HAVE TO USE?___ _____

13. DO YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS DUE TO THE INJURY?

HEADACHES_____ DIZZINESS —— MEMORY LOSS ____ CONCENTRATION DEFICITS_____

NAUSEA_____ VOMITING ____ BLADDER DISTURBANCE ____

WEAKNESS _____ NUMBNESS ____ BOWEL URGENCY/ACCIDENTS_____

FATIGUE_____ ANXIETY _____ BLADDER URGENCY/ACCIDENTS ____

DEPRESSION _____ SWELLING _____ DIFFICULTY WALKING_____

IRRITABILITY_____ HAIR LOSS_____ SKIN COLOR CHANGES _____

WEIGHT GAIN/LOSS___ LBS COLDNESS ____ WARMTH

14. PLEASE RATE YOUR PAIN: _____

0 1 2 3 4 5 6 7 8 9 10
(NO PAIN) (EXTREME PAIN)

PAIN LEVEL TODAY————— AVERAGE DAY_____ GOOD DAY_____ BAD DAY _____

15. WHAT MAKES YOUR PAIN BETTER? (PLEASE CHECK ALL THAT APPLY)

LYING DOWN——— WALKING_____ SITTING _____ STANDING_____ MEDICATION_____

SLEEP ——— HEAT——— MASSAGE____ EXERCISE ——— STRETCHING ____

TRACTION _____ TENS____ CORSET_____ BIOFEEDBACK—— COMPRESSION____
OTHER? _____

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16. WHAT MAKES YOUR PAIN WORSE?

STANDING _____ SITTING_____ BENDING_____ TENSION_____

LYINGDOWN ____ LIFTING_____ WEATHER_____ DRIVING_____ SEXUAL ACTIVITY_____

WALKING_____ WALKING UP STAIRS _____ WALKING DOWN STAIRS_____

REACHING OVERHEAD____ _____ OTHER?_____

17. DO YOU HAVE SEVERE PAIN AT NIGHT? YES_____ NO _____

18. DOES PAIN WAKE YOU FROM SLEEP? YES_____ NO _____ HOW MANY TIMES?_____

WHAT POSITION, IF ANY, RELIEVES THE PAIN? _____

DO YOU-HAVE DIFFICULTY FALLING ASLEEP AT NIGHT? YES_____ NO_____

DO YOU WAKE UP UNUSUALLY EARLY IN THE MORNING? YES_____ NO_____

HOW LONG CAN YOU SLEEP? WITH MEDICINES: _____(HRS) WITHOUT MEDICINES: _____ (HRS)

19. PREVIOUS TREATMENT (CHECK ALL THAT APPLY)

MODALITY	TEMPORARY RELIEF	LASTING
PHYSICAL THERAPY		
ULTRASOUND__ HOTPACKS__ TRACTION___	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__
SOFT TISSUE RELEASE _____	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__
ELECTRICAL STIMULATION_____	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__
THERAPEUTIC EXERC|SE _____	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__
TENS_____	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__
BIOFEEDBACK_____	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__
CHIROPRACTOR _____	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__
PSYCHOLOGICAL SUPPORT_____	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__
BRACE SPLINT/CERVICAL COLLAR___	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__
WORK HARDENING_____	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__
INJECTIONS (HOW MANY TIMES? WHICH ONE?)		
TRIGGER POINT__ FACET BLOCK__ EPIDURAL__	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__
NERVE BLOCK___ SYMPATHETIC BLOCK _____	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__
ACUPUNCTURE_____	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__
IMPLANTS ___WHEN?___ WHERE?____	YES__ NO__ HRS__ DAYS__	YES__ NO__ HRS__ DAYS__

HAVE YOU BEEN SEEN AT A PAIN CLINIC? NO —— YES____ WHEN?____ WHERE?_____

LIST NAMES OF PSYCHOLOGIST OR PSYCHIATRIST:

20. LIST OTHER TREATING PHYSICIANS, REHAB NURSES, THERAPISTS,VOCATIONAL COUNSELORS AND THEIR RECOMMENDED TREATMENTS

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21. CHECK ALL DIAGNOSTIC TESTS THAT YOU HAVE HAD?
(PLEASE INDICATE WHERE THESE TESTS WERE TAKEN SO THAT WE CAN OBTAIN RESULTS)

PLAIN X-RAYS_____ CAT SCAN_____

MRI SCAN _____ _ EMG/NCV_____

MYELOGRAM _____ OTHER _____

PAST MEDICAL HISTORY:

22. PLEASE LIST ANY INJURIES YOU HAVE HAD SINCE THE ACCIDENT YOU ARE HERE FOR TODAY:

_____

PLEASE LIST ANY PREVIOUS INJURIES (FALLS, AUTO ACCIDENT, WORK, OTHERS (DESCRIBE WHERE AND HOW INJURIES OCCURRED)?

_____

_____

LOW BACK PAIN IN THE PAST? YES___ NO___ LEG PAIN? YES___ NO___ RIGHT___ LEFT___ BOTH___

HOW LONG DID PAIN LAST RELATED TO THE ABOVE PAST INJURIES _____

WAS RESOLUTION OF PAIN COMPLETE YES___ NO___ OR INCOMPLETE _____

23. CHECK ANY PREVIOUS MEDICAL PROBLEMS:

HEART DISEASE_____ LUNG DISEASE _____ KIDNEY DISEASE_____ INTESTINAL DISEASE_____

THYROID_____ DIABETES_____ HIGH BLOOD PRESSURE____ CANCER_____

STROKE _____ SEIZURE_____ BLOOD CLOTS_____ OSTEOARTHRITIS_____

RADICULOPATHY_____ DISC DISEASE_____ CARPAL TUNNEL_____ AMPUTATIONS_____

NERVE INJURIES_____ HEPATITIS_____ BLEEDING DISORDERS_____

INFECTIOUS DISEASES_____

LIST ANY PREVIOUS SURGERIES _____

_____

24, LIST ALL CURRENT MEDICATIONS:

NAME DOSE (MGM) TIMES/DAY NAME DOSE (MGM) TIMES/DAY

_____

_____

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25. ARE YOU CURRENTLYWORKING? YES___ NO_____ FULL DUTY_____ LIGHT DUTY _____
HOW LONG HAVE YOU BEEN OUT OF WORK?_____

HAVE YOU TRIED TO RETURN TO WORK? YES___ NO__ WHEN?_____

HOW LONG DID YOU WORK WHEN YOU RETURNED?_____WHY DID YOU STOP?_____

TYPE OF JOB: _____HOW LONG?_____REASON FOR LEAVING_____

NUMBER OF HOURS _____OCCUPATION (JOB TITLE)_____

JOB DESCRIPTION (WORK DUTIES) _____
EMPLOYER_____
NUMBER OF HOURS: SITTING_____ STANDING_____ BENDING_____

OVERHEAD WORK ___ CLIMBING_____ COMPUTER_____
REPETITIVE UPPER EXTREMITY _____ LIFTING _____

26. SOCIAL AND FAMILY HISTORY:
MARITAL STATUS: MARRIED _____ SINGLE ____ SEPARATED ____DIVORCED____ WIDOWED_____
YOUR SPOUSE HEALTHY? YES ___ NO___ VERBAL OR SEXUAL ABUSE _____
NUMBER OF CHILDREN_____AGES _____
IS THERE A HISTORY OF VERBAL OR SEXUAL ABUSE?_____
WHAT IS YOUR EDUCATIONAL LEVEL? _____

HAVE YOU EVER SMOKED? YES___NO___ AGE STARTED_____ AGE STOPPED_____
CUP OF COFFEE _____ TEA_____ SODA_____ PER DAY_____
RECREATIONAL DRUGS? YES_____NO_____
HAVE YOU EVER OR DO YOU NOW DRINK ALCOHOL? YES _____NO_____
DO YOU HAVE ANY FAMILY MEMBERS WHO DRANK EXCESSIVELY? YES ____ NO_____

ANY FAMILY MEMBERS WITH ARTHRITIS, NECK OR BACK SURGERIES?
YES_____NO_____WHO_____

27. STRESSES:
RELATIONSHIPS: FAMILY, FRIENDS, JOB, HOME, ETC. (PLEASE EXPLAIN): _____

_____

28. PLEASE DESCRIBE YOUR DAILY ROUTINE: _____

---

29. DESCRIBE YOUR REGULAR EXERCISE ROUTINE AND FREQUENCY (ie. WALKING, STRETCHING, OTHERS)
_____

DO YOU LIKE TO EXERCISE? YES____ NO_____, IF NO, WHY?_____

DO YOU HAVE TIME TO EXERCISE?

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30. REHABILITATION IS A GOAL ORIENTATED PROCESS. IT IS IMPORTANT TO SET REASONABLE GOALS AND EXPECTATIONS. PLEASE LIST YOURS IN THE SPACE PROVIDED BELOW.

GOALS: SHORT-TERM (NEXT 3-6 MONTHS)

_____

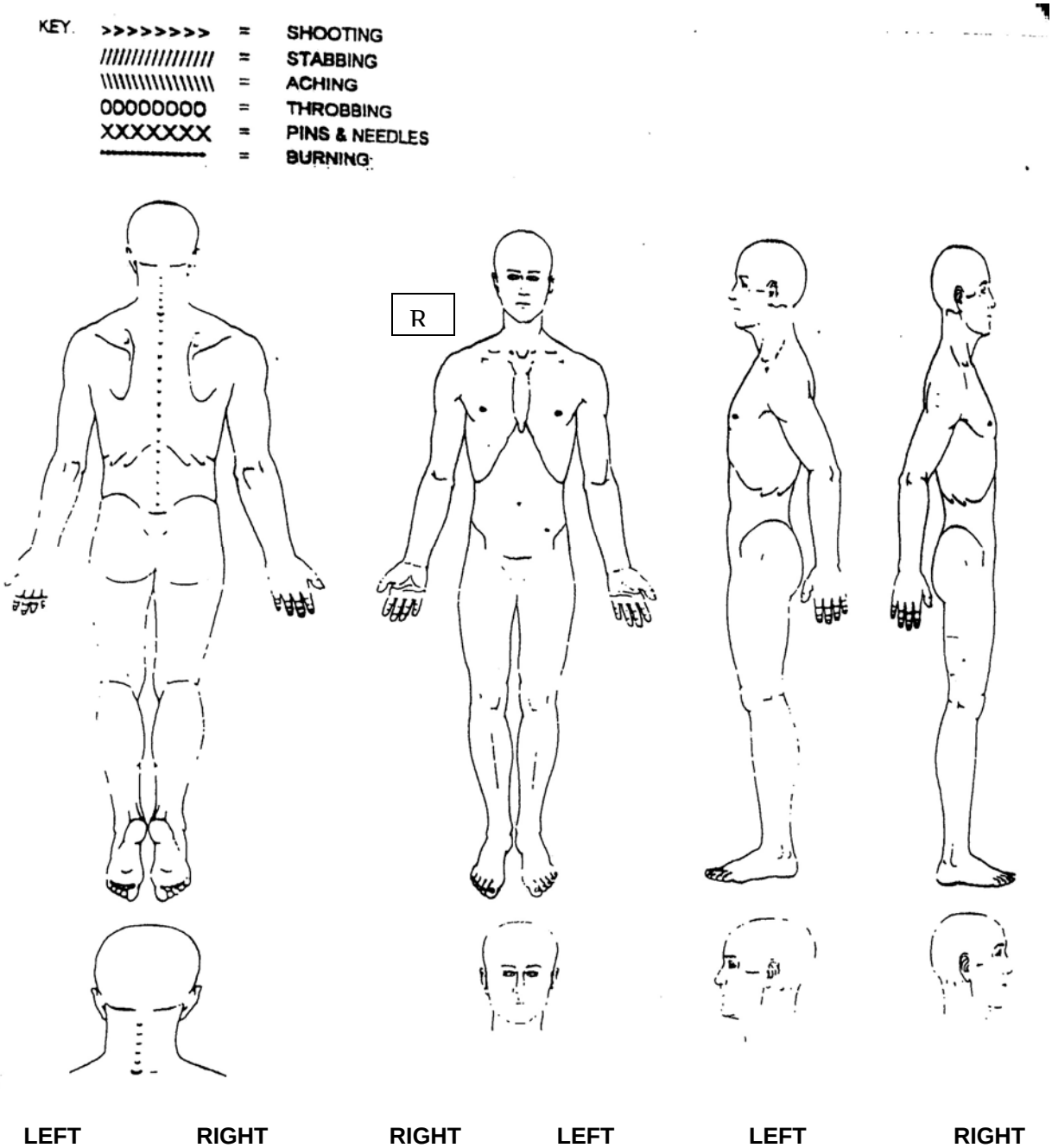
_____

GOALS: LONG-TERM(6 MONTHS OR MORE)

_____

_____

PAIN DIAGRAM: USING THE PAIN DESCRIPTION, PLEASE MARK THE AREAS OF YOUR PAIN. PLEASE NUMBER EACH PAINFUL AREA IN ORDER OF THE MOST TROUBLESOME, I.E., 1-10 ON THE DIAGRAM.



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PAIN DISABILITY INDEX Patient's name (please print)_____ date _____

Rating scales below measure the impact of chronic pain in your everyday life. We want to know how much the pain is preventing you from doing your normal activities. For each of the 7 categories of life activity listed, circle the one number that best reflects the level of disability you typically experience. A score of "0" means no disability at all. A score of "10" means that all the activities which you normally do have been disrupted or prevented by your pain. The ratings should reflect the overall impact of pain in your life, not just when the pain is at its worst. Make a listing for every category. If you think a category does not apply to you, circle "0".

Family/home responsibilities: This category refers to activities related to the home or family. It includes chores and duties performed around the house (eg., yardwork) and errands or favors for other family members (eg., driving the children to school).

0	2	3	4	5	6	7	8	9	10
No disability		Mild		Moderate		Severe		Total disability	

Recreation: This category includes hobbies, sports and other leisure time activities.

0	2	3	4	5	6	7	8	9	10
No disability		Mild		Moderate		Severe		Total disability	

Social activity: This category includes parties, theater, concerts, dining out, and other social activities that are attended with family and friends.

0	2	3	4	5	6	7	8	9	10
No disability		Mild		Moderate		Severe		Total disability	

Occupation: This category refers to activities that are directly related to one's job. This includes non-paying jobs as well, such as that of a homemaker volunteer.

0	2	3	4	5	6	7	8	9	10
No disability		Mild		Moderate		Severe		Total disability	

Sexual behavior: This category refers to the frequency and quality of one's sex life.

0	2	3	4	5	6	7	8	9	10
No disability		Mild		Moderate		Severe		Total disability	

Self-care: This category includes personal maintenance and independent activities (example taking a shower, driving, getting dressed)

0	2	3	4	5	6	7	8	9	10
No disability		Mild		Moderate		Severe		Total disability	

Life-support activity: This category refers to basic life-supporting behaviors such as eating, sleeping and breathing.

0	2	3	4	5	6	7	8	9	10
No disability		Mild		Moderate		Severe		Total disability	

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