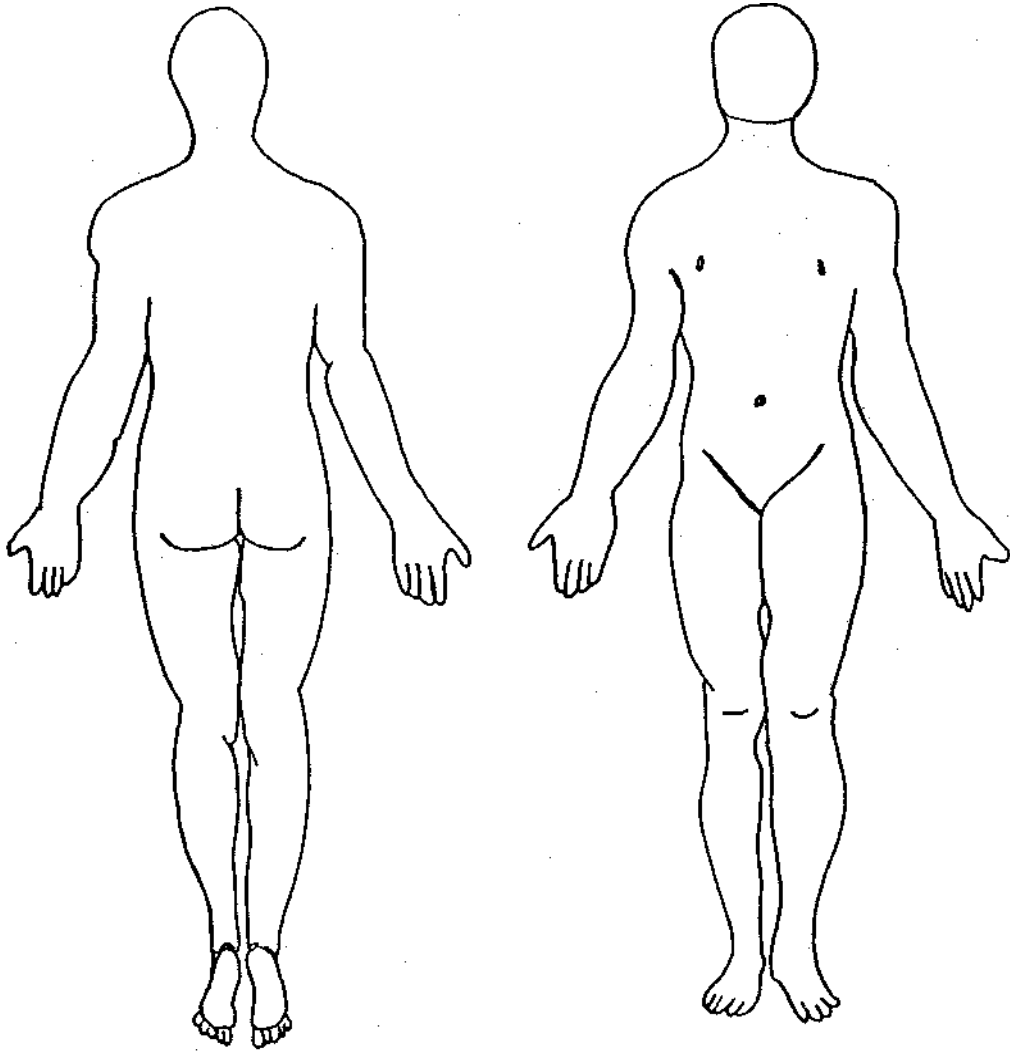


NAME: _____ DATE: _____

PLEASE FILL OUT THIS PAIN DIAGRAM TO THE BEST OF YOUR ABILITY. MARK THE AREAS ON YOUR BODY WHERE YOU HAVE PAIN, AREAS OF NUMBNESS OR TINGLING, OR ANY OTHER BOTHERSOME SENSATION. PLEASE INCLUDE ALL AFFECTED AREAS AS WELL AS THE RADIATION OF SYMPTOMS. USE THE APPROPRIATE SYMBOLS BELOW. **PLEASE FILL OUT THE PAIN SCALE.**

NUMBNESS:00000 PINS & NEEDLES:XXXXX PAIN OR ACHE:////



RATE YOUR PAIN

0=NO PAIN

10=EXTREMELY INTENSE

| | | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|---|----|
| RIGHT NOW: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| AT ITS WORST: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| AT ITS BEST: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**DR. STEVEN C. DENNIS - PATIENT INFORMATION
HISTORY & PRESENT STATUS OF THE PAINFUL BACK AND NECK**

PATIENT NAME: _____ **AGE:** _____ **DATE:** _____

CHIEF COMPLAINT:

ONSET: Sudden _____ Gradual _____ Date _____ Time of Day _____

Comments: _____

***CAUSE** – injury, sickness, etc.

****IMMEDIATE SYMPTOMS** _____

COURSE: Detailed chronological study of symptoms & medical care & reaction to each procedure (hospitalizations/studies/surgeries):

PAST RELEVANT HISTORY: Previous/Recent Attacks:

| | | | | | |
|----------------|------------|---|---|---|---|
| PRESENT | Pain | 1 | 2 | 3 | 4 |
| | Function | 1 | 2 | 3 | 4 |
| | Occupation | 1 | 2 | 3 | 4 |

PROG RESS Better, Worse, Stationary _____

* Describe carefully just how forces of the accident affected the patient, how he was thrown, fell, landed, twists to the back or limbs. Just mechanical factors (don't include extraneous material as who was to blame).

** How patient felt immediately – unconscious, how long: ache, severe pain, gradual increase, inability to walk or use certain joints, numbness and/or paralysis.

History and Present Status of the Painful Back and Neck

Patient's Name: _____

RELATION TO ACTIVITY

Position of greatest comfort? _____

Does rest or activity relieve? _____

My pain is (check appropriate response) BETTER WORSE NO DIFFERENT

With cough or sneeze

With straining

Sitting in a straight chair Sitting in a

soft easy chair Sitting for a long

length of time Bending forward to

brush your teeth

Walking on a flat surface

Walking up stairs

Walking down stairs

Walking a distance

After walking, when bending forward

Lying flat on stomach

On side with knee(s) bent

When bending

When lifting

When working overhead

Lying on back

Standing

Walking – distance _____ What happens? _____

Do you exercise on a regular basis? YES _____ NO _____

What time of day is your pain worse? _____

Does the pain wake you from sleep? _____

NEUROLOGICAL EFFECTS:

% Pain: LBP _____ Legs: R _____ L _____ /NECK _____ Arms: R _____ L _____

Radiation of Pain: Where? _____ When? _____

Areas of skin tingling, numbness, coldness _____

Muscle weakness? _____

Patient's Name: _____

CHRONIC INFLAMMATORY FACTORS:

Stiffness after rest: Getting out of bed _____ After sitting _____

Effect of change of weather _____ Cold/damp weather _____ Hot _____

Effect of heat to part _____ Type of heat _____

Women/relation to menstrual periods _____

TB
HEPATITIS/JAUNDICE
PNEUMONIA

SYPHILLIS
GONORRHEA
OTHER INFECTIONS

CURRENT HISTORY

Did you have to change jobs? Yes ___ No ___ If Yes, to what? _____

Are you under any pressure at home? _____ At work? _____

If yes to the above – please rate: Mild Moderate _____ Severe _____

What can't you do (that you want/would like to do), because of the pain you are experiencing?

Current medications? _____

Other medications taken in the past _____

What was the date of your last physical exam _____ MD Name _____

Pelvic exam date _____ Rectal exam date _____

HOSPITALIZATIONS

Have you been in the hospital with other medical problems? _____

Number of times: _____ Please describe: _____

Have you ever had a transfusion before? Yes _____ No _____

Number of times: _____ Please describe: _____

Do you have an attorney assisting you? _____