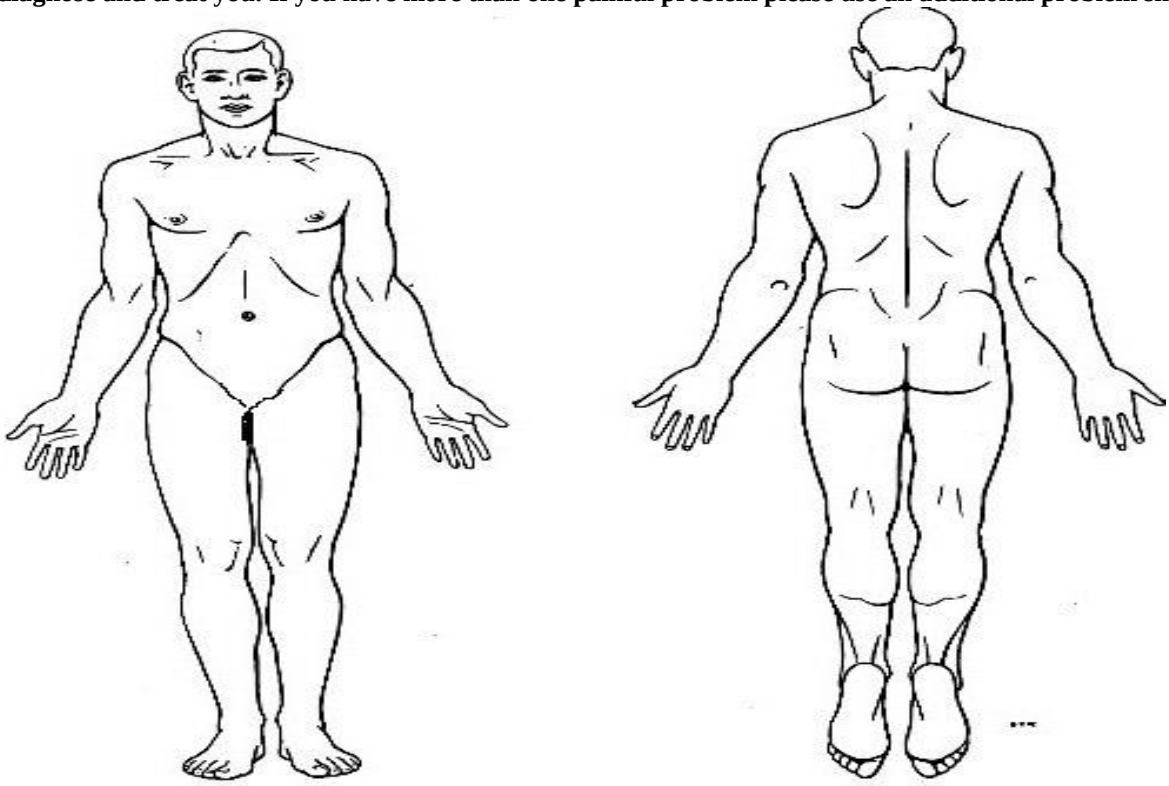
INTERNATIONAL HOUSE OF PAIN CLINIC INITIAL VISIT

www.internationalhouseofpain.com

Please completely fill out the form below. *The more complete you are, the better i can care for you. for you*!

NAME: **DATE:**

This is a problem sheet. Please use this sheet to describe ONE pain you are having. The more complete you are the more likely it is we can diagnose and treat you. If you have more than one painful problem please use an additional problem sheet.



Please indicate the location of your symptoms using the following symbols:

N = Numbness or Loss of Sensation
P = Pins and Needles
B = Burning/fire
T = Tenderness to touch or pressure
A = Achyness
K = Knifelike or Stabbing
E = Electrical
S = Superficial
D = Deep
G = Shooting pain

→*WHEN DID THE PAIN START?:*

VAS: Please circle/rate your ***AVERAGE PAIN LEVEL OVER THE PAST WEEK***

0 1 2 3 4 5 6 7 8 9 10

0-10 scale with 0=No Pain and 10=The Most Pain Imaginable

***Pain is*: Improving** or **Worsening** or **Stable / Constant** or **Intermittent**

***Pain is due to:* Car Accident / Work Injury / Sport Injury / Aging / Disease / Other:**

***What increases pain?:* Standing / Sitting / Lying down / Walking / Twisting / Driving / Reaching / Change in weather / Cough / Sneeze / Leaning forward / Leaning backwards / Other:**

***What reduces pain?:* Standing / Sitting / Lying down / Walking / Twisting / Heat / Cold / Change in weather / Leaning forward / Leaning backwards / Meds / Massage / Other:**

Please describe the *history* of this pain:

A) Name:_____ B) Date of Birth:_____
C) AGE:_____ D) SEX: M F
E)Date:_____ F) Referred by:_____
G: EMAIL:_____ Cell Phone/Active Home phone#:_____

H. FUNCTIONAL HISTORY

1. How far can you walk? _____ 2. How long can you sit? _____
3. How long can you sleep?_____ 4. How long can you stand? _____

I. FUNCTIONAL GOALS:

Please circle your functional goals:

1. Incr. sitting tolerance 4. Incr. standing tolerance 7. Incr. walking distance
2. Improved sleep 5. Incr. stamina/endurance 8. Incr. mobility
3. Incr. social independence 6. Improved quality of life

J. MEDICAL ALLERGIES: None

1. Penicillin:	**Y**	**N**	**2. Cipro**	**Y**	**N**
3. Sulfa:	**Y**	**N**	**4. Ancef or cefazolin**	**Y**	**N**
5. Cleocin or clindamycin	**Y**	**N**	**6. Bacitracin**	**Y**	**N**
7. Keflex or cephalexin	**Y**	**N**	**8. Shellfish**	**Y**	**N**
9. Egg or Chicken	**Y**	**N**	**10. Local anesthetic**	**Y**	**N**

Other Allergies:_____

K.MEDICINES YOU ARE TAKING: (please list, or attach a complete list

_____

_____

L. MEDICAL HISTORY(please include date of diagnosis if known) None

1. Y N High blood pressure Date: _____ 2. Y N Diabetes Date: _____
3. Y N Rheumatoid Arthritis Date: _____ 4. Y N Heart Attack Date: _____
5. Y N Stroke Date: _____ 6. Y N Bleeding problems or Coumadin blood thinner?
7. Y N Ulcers in stomach or bowels Date: _____ 8. Y N Asthma Date: _____
9. Y N Emphysema or COPD Date: _____ 10.Y N Chronic Bronchitis Date: _____
11. Y N Gout Date: _____ 12.Y N Cancer : Type___Date: _____
13. Y N Atrial Fibrillation Date: _____ 14.Y N Pancreatitis Date: _____
15. Y N Hepatitis Date: _____ 16.Y N HIV or AIDS Date: _____
17. Y N Kidney or gall stones Date: _____ 18.Y N Brain injury Date: _____
19. Y N Psychiatric illness Date: _____ 20.Y N Depression Date: _____

OTHER MEDICAL HISTORY:

_____

_____

M. SURGICAL/ PROCEEDURAL/ THERAPEUTIC HISTORY (with dates please)

(Circle Y or N- no response if uncertain)

1. Y N Heart DATE:_____ 2. Y N Appendectomy DATE:_____
3. Y N Gallbladder DATE:_____ 4. Y N Hysterectomy DATE:_____
5. Y N Breast DATE:_____ 6. Y N Prostate DATE:_____
7. Y N Low Back DATE:_____ 8. Y N Neck DATE:_____
9. Y N Joint Replacement Which?_____ DATE:_____
10. Y N Physical Therapy: DATE:_____
11. Y N Epidural, by whom:_____ DATE:_____
12. Y N Other Injection:_____ DATE:_____
13. Y N MRI of what area:_____ DATE:_____

14. Y N CAT of what area:_____ DATE:_____
15. Y N Bone scan DATE:_____
16. Y N X-Ray of what area:_____ DATE:_____
Other Surgery:_____
_____
_____

N. SOCIAL HISTORY (write or circle most appropriate):

Age:_____ Gender: M F
Race: Native-American White Black Hispanic Asian Indian Arab Pacific-Islander Carib
In what city do you live now?: _____ Ft. Laud
Occupation (or former):_____ Are you currently working?: Y N
Last grade finished: Grade School HS GED Trade School College Post-Grad.
Disability: SSI / Medicare / Private
Married Separated Divorced Single Widowed
Number of children you have: _____
Live: Alone / Spouse / Children / Parents / Significant other
Do you use illicit drugs or use drugs illegally? Y N
Never smoked_____ Former Smoker____ When Quit?: _____ Current Smoker____ Packs per day: _____
Ever chewed tobacco? Y N
Do you drink alcohol?: Past Now Never Drinks per week:_____

O. IMMEDIATE FAMILY MEDICAL HISTORY:

1. Y N Diabetes: 2. Y N High Blood Pressure
3. Y N Coronary artery disease 4. Y N Heart attack
5. Y N Stroke 6. Y N Kidney disease
7. Y N Cancer 8. Y N Genetic disease
9. Y N Neurological disease

P. ROS/REVIEW OF HEALTH PROBLEMS:

(Circle Y or N)

SKIN:

1. Y N Any open sores? Or areas of infection? 2. Y N Recent changes in itching, rashes or sores?
3. Y N Recent changes in lumps or moles?

CONSTITUTIONAL:

4. Y N Weight loss without dieting 5. Y N Weight gain
6. Y N Fevers 7. Y N Night sweats

NEUROLOGIC:

8. Y N Headaches? 9. Y N Seizures/Epilepsy/ Loss of consciousness?
10. Y N Lack of sensation anywhere in your body?
Where_____
11. Y N Numbness or tingling anywhere in your body?
Where_____

GASTROINTESTINAL:

12 Y N Nausea? 13. Y N Vomiting ?
14 Y N Diarrhea? 15. Y N Constipation?
16. Y N Change in stool color or blood?

EYES:

17. Y N Visual changes?

EARS/NOSE/THROAT:

18 Y N New changes in hearing? 19. Y N Vertigo?
20. Y N Discharge from ears or eyes? 21. Y N Runny nose or bloody nose?
22. Y N Recent sore throat or mouth sores?

RESPIRATORY:

23. Y N Shortness of breath? **24. Y N Wheezing, coughing, or sputum production?**

CARDIAC:

25. Y N Hypertension? **26. Y N Angina or chest pain with exertion?**

27. Y N Extremity swelling or color change?

GENITOURINARY:

28. Y N Urinating more often than normal? **29. Y N A sense of urgency in getting to the bathroom?**

30. Y N Urinary infection?

MUSCULOSKELETAL:

31. Y N General muscle weakness? **32. Y N General muscle pain?**

33. Y N Joint stiffness or diminished ROM? **34. Y N Painful joints?**

CRITICAL:

35. Y N L*oss of sensation* in the genitals? **36. Y N Loss of bladder control?**

37. Y N Loss of bowel control? **38. Y N Any *recent trauma* to your body?**

39. Y N O*steoporosis* (thinning of the bones)? **40. Y N History of *cancer*?**

41. Y N Do you have *HIV or AIDS*? **42. Y N Have you had a *transplant*?**

43. Y N Have you any history of *IV drug use*? **44. Y N Is your pain *increased by rest*?**

45. Y N Have you had recent *fevers* or *night sweats*? **46. Y N Any *bladder dysfunction*?**

47. Y N Any *weakness* in your extremities? **48. Y N Any *insomnia*?**

49. Y N ANY implants? *e.g.* new knee or hip? **50. Y N Do you have an *artificial heart valve*.**

51. Y N Do you *presently* have a *heart murmur*? **52. Y N Any recent dental infections or other bodily infections?**

53. What is your height?:_____ **54: What is your weight?: _____**

To our patients:

Thank you for taking the time to complete this initial history. This is a long form, but we believe in attention to detail. We look forward to and thank you for the opportunity to work with you. While medical care has advanced enormously in the field of pain, durable pain relief and lasting functional improvement requires your active participation in the treatment plan. Your healing is a journey we will take together, a journey toward making you whole again. This is our passion. Seeing your relief from pain and increase in function is extremely rewarding for us. Improvement in our patients' quality of life is the cornerstone of existential satisfaction for you, and for us. Welcome.

OFFICE USE BELOW:

1) **Vital Signs:**
Height:_____ Weight:_____ Resp.:_____

2) **Constitutional:** Nl dev.____ Well groomed____ Appears stated age:_____ NAD____

SCOPE: H,N/BUE or TLS/BLE

3) **Skin:** a) Rashes_____ b) Sores_____ c) Open wounds___ d) Erythema __ e) drainage_____ f) increased warmth_____

4) **Cardiovascular**: a) Edema:_____ b) Venous Pigmentation_____ c) Pulses :_____

5) **Psych and Neuromusculoskelal:** a) Orientation:_____ b) Depression:, anxiety, agitation::_____ c) Gait: Antalgic_ Tberg_____
d) Coordination: _____e)DTR: _____ f) Hoffman/Clonus:_____ g) Sensation____ h) MMT:_____ i)Gross dislocation, subluxation or laxity: _____

6) Lumbar Spine : a) gross deformity____b) malalignment____c) AROM: FLEX:0-___ (90n.) EXT:0-___ (25n.) R Lat flex 0-___ (25n.) L Lat flex 0-__ 25n.)
d) Muscular TTP____ (Glut Med.) (Quad Lumborum) (Paraspinal mm.) e) Spinous Process TTP_____ f) Facet TTP R_____L_____ g)Facet J. Load R_____ L _____
h) SLR R_____ L_____ i) SLUMP R_____ L_____ j) Fortin Fing T R_____ L_____ k) Patrick/FAB R_____ L_____ l) Gaenslen R_____ L_____
m) PiriformisPalp R_____ L_____ n) FADIR R_____ L_____ o) Pace R_____ L_____ p) Seg. Mot. R_____ L_____

7) Cervical Spine a) Abn/Def on inspection_____ b) TTP fontal occipital temporal c) AROM: FLEX:0-___ (50n.) EXT:0-___ (60n.) R Lat flex 0-___ (45n.) L Lat flex 0-___ (45n.) DextroRot:____ (80n) LevoROT_____(80n) d)TTP spinous processes _____ e) Facet TTP R_____L_____
f) Myofascial exam TTP: 1) Traps R_____L_____ 5) Rhomboid R_____L_____ 2) Supraspinatous R_____L_____ 6) Levator Scap R_____L_____
3) Infraspinatous R_____L_____ 7) Mid Scalene R_____L_____ 4)Deltoid R_____L_____ 8) Post Scalene R_____L_____
g) Spurlings R_____L_____
h) L'Hermitte R_____L_____

CONS: 99241-15 42-30 43-40 44-60 45-80 EVAL:99201-10 02-20 03-30 04-45 05-60