6410 Rockledge Drive, Suite 110, Bethesda, MD, 20817 (O) 301.530.7303 (F) 301.530.7312
2112 F Street, NW, Suite 802A, Washington, DC, 20037 (O) 202.775.7246 (F) 202.775.2345

NAME: ____ **DATE:** ____________

Home Phone: ____________________ Work Phone: _______________________

Cell Phone: ______________________ Who to call in case of emergency: ___________

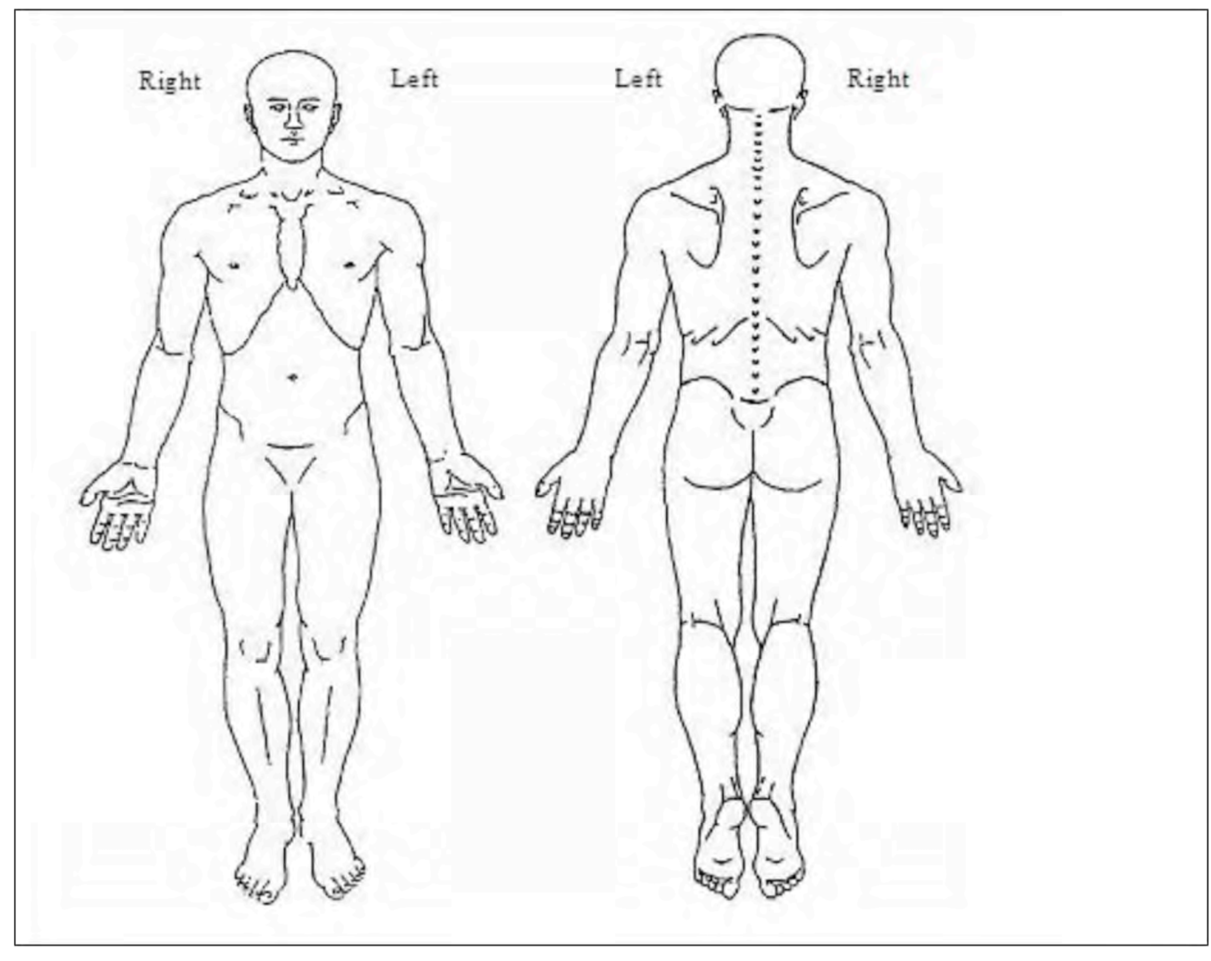
Name of the doctor who has referred you: _____________________________________

Names of doctors who should get this report: ___________________________________

REASON FOR VISIT: ____

The worst area(s) of pain: ____

Please mark the areas of pain



Please rate your average daily pain: from 0 (no pain) to 10 (worst possible pain): /10

Length of time that you have had this pain in this area: ________________________

Has something or an event started your pain? YES NO If so what event?
____

Circle factors that aggravate your pain? None Standing Exercising Walking Bending Straining Lifting Stress Weather changes Medications Repetitive motions Sitting Head movement Mood swings Light touch Deep breathing Coughing Bearing down Lying down Rolling in bed Other ______________________________________

Circle factors that help your pain: Nothing Resting Walking Standing Sitting Moving Physical therapy Massage Heat/Ice packs Medication Lying down Changing Positions Other____

Circle all characteristics of your pain: Constant Intermittent Burning Sharp Shooting Aching Throbbing Tingling Numbness Other _________________________

Circle prior treatments:
Anti-inflammatory medications: (example Ibuprofen), Celebrex, Medrol dose pack
Narcotics: Ultram (tramadol), Percocet, Oxycodone, Oxycontin, Vicoden, Hydrocodone, Morphine, Methadone, Dilaudid, Hydromorphone, Duragesic, Actiq
Antidepressants: Elavil (Amitriptylline), Pamelor (nortriptylline), Trazodone, Desipramine, Cymbalta
Antiseizure medication: Neurontin, Trileptal, Topamax, Gabitril, Lyrica
Acupuncture, Magnets, Massage, Chiropractic manipulation, Herbs, Physical therapy
Nerve Blocks , Epidural injections, Facet blocks , other ___________________________

ALLERGIES: ____

ALL CURRENT MEDICATIONS YOU ARE TAKING: ______________________
____
____
____

PAST AND PRESENT MEDICAL ISSUES/DISEASES: ______________________
____
____
____

PAST SURGERIES: ____
____
____

FAMILY HISTORY:

	Age	Significant health problems
father		
mother		
brother		
sister		

SOCIAL HISTORY: Circle all that applies to you.
Single   Married   Divorced   Separated   Widowed   Partnered
Do you have children? Yes No How many? ________________________________
Do you work?   Yes   No   If so, describe please______________________________
Do you Smoke? Yes   No   How much? _____________________________________
Do you drink?   Yes   No   How much? _____________________________________
Do you use illicit drugs? Yes   No   How much? ____________________________
Have you ever been addicted to nicotine, alcohol, or illicit drugs? If so, Please explain
____
Are you involved in any unsettled legal issues involving your symptoms?   Yes   No
If so, please explain:
____
____

GENERAL HEATH QUESTIONS: Have you had any of the following in the past 2 weeks? (Circle all that applies to you)
Fevers   Chills   Night sweat   Unexplained weight loss   Eye problems Ear problems Heart problems Lung problems Stomach problems Bladder /kidney problems Skin problems Neurological problems Psychological issues Thyroid problems Diabetes Bleeding problems

Please explain any of the above:
____
____
____
____
____