| Patient Initial Evaluation<br>History & Physical Form | Pain Control Associates, L.L.C. |
|---|---|

Date: _____

_____

Last Name First Name Date of Birth Age

_____

Referring Physician / Primary care Physician Phone Number

Reason for the visit today: _____
How long have you had the problem: _____
Factors of complaint (How your pain or problem began): _____

**Current Medications** (May Attach a list)

| Name | Dose | # Per Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Allergies** (May attach a list)

| Substance | Reaction |
|---|---|
| | |
| | |
| | |

## Medical History and Review of Systems

**Neurological**
- Seizures □Yes □ No
- Strokes □Yes □ No

**Cardiovascular**
- Chest Pain □Yes □ No
- Heart Attack □Yes □ No
- Irregular Heartbeat □Yes □ No
- High Blood Pressure □Yes □ No
- Anticoagulants □Yes □ No
- Murmur □Yes □ No
- Blood Clots □Yes □ No

**Ear, Nose & Throat**
- Nose bleeds □Yes □ No
- Sinus □Yes □ No
- Hard of hearing □Yes □ No
- Difficulty Swallowing □Yes □ No
- Cataracts/Glaucoma □Yes □ No

**Recreational Drug Use** □Yes □ No

**Diabetes** Blood Sugar Values _____
- Insulin Use □Yes □ No
- Hepatitis □Yes □ No

**Gastrointestinal**
- Ulcers □Yes □ No
- Reflux Disease □Yes □ No

**Respiratory**
- Asthma □Yes □ No
- Emphysema □Yes □ No
- Tobacco Use □Yes □ No
- (Type/ PPD) □Yes □ No

**Bowel / Bladder**
- Diarrhea □Yes □ No

**Psychosocial**
- Depression □Yes □ No
- Anxiety □Yes □ No

**Alcohol Use**
Type / Amount _____

# Patient Initial Evaluation
# History & Physical Form

Pain Control Associates, L.L.C.

Date: _____

_____

Last Name First Name Date of Birth Age

Please number and mark the **severity of pain** you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

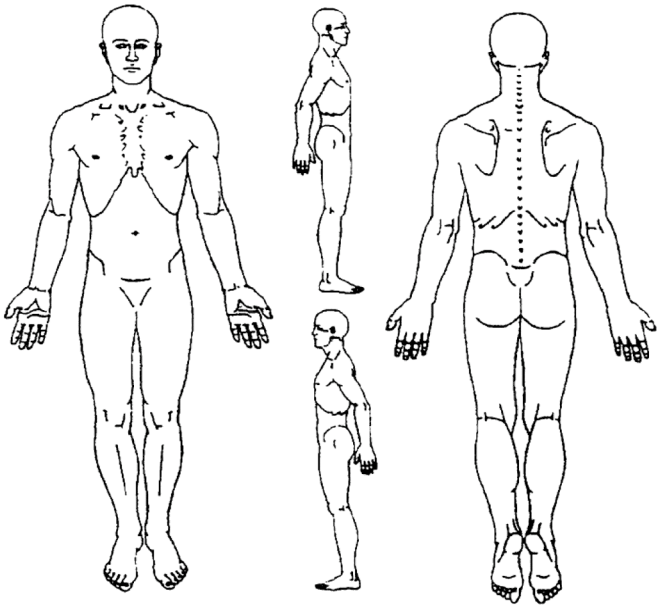
- Current pain: /10 0 1 2 3 4 5 6 7 8 9 10
- Average pain: /10 0 1 2 3 4 5 6 7 8 9 10

(Visual Analog Pain Severity Scale)

Please describe the **type of pain** or sensation you are currently experiencing. (Check all that apply)

☐ Aching ☐ Burning
☐ Cramps ☐ Dull
☐ Numbness ☐ Sharp
☐ Shooting ☐ Stabbing
☐ Stiffness ☐ Swelling
☐ Throbbing ☐ Tingling
☐ Other, describe it: _____

Please mark on the diagram the location of the pain.



- When did the pain begin? _____ Any flare-ups since then? If so, when?_____
- What brought the pain on?
  _____
- The pain ☐ is constant ☐ comes and goes. If it comes and goes, how often does the pain exist?
  _____
  And for how long?

_____

- Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other_____
- Activities or movements that are painful to perform:
  ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐None ☐Other_____
- When and what makes it better?
  _____
- When and what makes it worse?
  _____
- Any prior injuries to the area of pain?
  _____
- Have you seen another healthcare practitioner for the pain/condition? Yes / No
- If yes, who?
  _____

Patient Initial Evaluation
History & Physical Form

Pain Control Associates, L.L.C.

_____

Last Name First Name Date of Birth Age

**Medical History**

_____
_____
_____
_____
_____
_____

**Surgical History:**

| Type of Surgery/Procedure | Dates |
|---|---|
| | |
| | |
| | |
| | |

**Social & Work History**

_____
_____
_____
_____
_____

**Physical Exam:**

Height: _____ Weight: _____ Age: _____

Vitals: _____ P _____ R _____ T _____

Heart: _____ _____ Lungs: _____
Extremities: _____
Abdomen: _____
Spine: _____

**Clinical Notes:**

_____
_____
_____
_____
_____
_____

**Imaging Studies**: **CT SCAN**: □ **MRI**: □ **EMG**: □ **BONE SCAN**: □ **X-Rays**: □

**Physician Signature:** _____ **Date:** _____