Patient name: _____ Visit Date: _____

LAS VEGAS PAIN INSTITUTE & MEDICAL CENTER, LLC

INITIAL EVALUATION

HISTORY OF PRESENT ILLNESS:

CHIEF COMPLAINT (please indicate right, left, or both sides):

_____

_____

How did the pain first occur? (Brief summary and approximate date)

_____

_____

_____

Describe the quality of pain you are having (Please Circle)

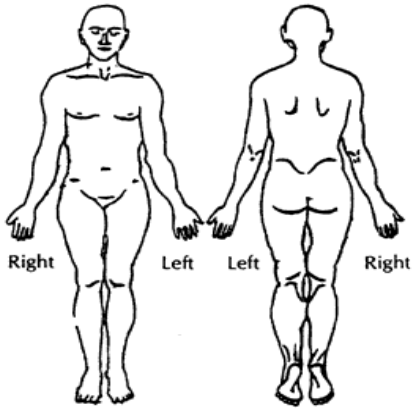
Constant	Electrical	Numbness
Intermittent	Tingling	Deep Ache
Dull Ache	Jabbing	Radiating
Burning	Knife like	Spasm

Describe the areas of discomfort (Use picture below to mark all areas of discomfort)

N = numbness	T = tingling	B = burning
A = ache	O = other	S = severe

Please rate your pain. (0 = no pain, 10 =excruciating)

Current pain: ____ Average pain: _____ Worst pain: ____ Best day: _____



Medical Assistant Initial: _____

Weight: _____ lbs

Height: _____

Blood Pressure: ____/_____

Heart Rate (HR): _____

Patient name: _____ Visit Date: _____

(mark all that applies for the following questions)

Timing of pain: □ all day □ in the morning □ in the afternoon □ in the evening □ at night □ at rest

Frequency of pain: □ daily □ weekly □ monthly □ yearly □ increasing □decreasing
□ unchanged

What triggers your pain: □ movements □ cold weather □ laying down □ standing □ sitting
□ bending □ activities

What helps with your pain: □ stretching □ laying down □ massage □ heat □ ice □ elevation □ rest
□ medications

Describe the severity of your pain during the past week:
□ None □ Mild □ Moderate □ Severe

Describe your limitations on daily activities:
□ None □ Moderate □ Unbearable

How often do you take medicine for pain relief:
□ Never □ Seldom □ fairly often □ regularly

What medicines do you take for pain? _____

_____

Current Medications: *(Write **ALL**, including over the counter medications and vitamins)*

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Drug Allergy (if not applicable, please mark □ **No Known Drug Allergies**)

	Allergen name	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Patient name: _____ Visit Date: _____

Medical History: *(diabetes, high blood pressure, cancer, thyroid, etc)*

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Surgical History (all types):

	TYPE	**DATE**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Accidents/injuries history:

	TYPE	**DATE**
1.		
2.		
3.		
4.		

Family History ***(****Other than self, has anyone in your immediate family had any of the following?)*

		Who?	**Living?**	**Deceased/age?**
Cancer	□ Yes □ No			
Tuberculosis	□ Yes □ No			
Diabetes	□ Yes □ No			
Heart Attack	□ Yes □ No			
High Blood Pressure	□ Yes □ No			
Stroke	□ Yes □ No			
Seizure	□ Yes □ No			
Asthma/emphysema	□ Yes □ No			
Thyroid disease	□ Yes □ No			
Kidney disease	□ Yes □ No			
Bleeding disorders	□ Yes □ No			
Stomach/duodenal ulcer	□ Yes □ No			
Mental Illness	□ Yes □ No			
Suicide	□ Yes □ No			

Social History

Marital Status: □ single □ married □ divorced □ separated □ widowed

How many children do you have? _____

Who lives with you? _____

Do you have any family or children that live locally? _____

Who accompanied you to this appointment? _____

Education level: *(check highest grade completed)*

□ Grade School □ High School □ College Degree

Employment: □ Student □ currently Employed □ Unemployed □ Retired □ Disabled (how long) _____

Tobacco history

Do you smoke**:** □ Yes □ No How many cigarettes per day? _____ How long? _____

If you quit smoking, when did you quit? _____

IV drug abuse? □ Yes □ No How much / how often / type _____

Alcohol History

How much alcohol do you drink on average?

□ None □ ____ drinks per day □ ____ per week □ ___ per month

What radiology services have you had in the last year?

	Body Part	**Location (where)**	**Date (year)**
MRI	_____	_____	_____
Cat scan	_____	_____	_____
X-ray	_____	_____	_____
Bone scan	_____	_____	_____
Ultra Sound	_____	_____	_____

Gastrointestinal

How is your appetite? □ Good □ Fair □ Poor

How are your bowel movements? □ Good □ Fair □ Poor

Diarrhea? □ Yes □ No

Constipation? □ Yes □ No

Do you use laxatives? □ Yes □ No

Any bowel or bladder incontinence (uncontrolled)? □ Yes □ No

Patient name: _____ Visit Date: _____

Psychiatric

Do you consider yourself: □ Tense □ Nervous □ Depressed □ Suicidal □ none

How many hours of sleep do you get each night? _____

Have you had emotional disturbances in the past? □ Yes □ No

Have you been physically abused? □ Yes □ No If yes, when? _____

Are you under the care of a psychologist? □ Yes □ No If yes, who? _____

Review of Systems: *mark all that applies (If yes, please note date of occurrence)*

		Date			***Date***
Heart Attack	□ Yes □ No		Joint Tenderness / Swelling	□ Yes □ No	
Coronary Artery Disease	□ Yes □ No		Gout	□ Yes □ No	
Heart Valve Problems	□ Yes □ No		Osteoporosis	□ Yes □ No	
High Blood Pressure	□ Yes □ No		Musculoskeletal Trauma	□ Yes □ No	
Irregular Heart Beat	□ Yes □ No		Anemia	□ Yes □ No	
Blood Clot	□ Yes □ No		Bruise Easily	□ Yes □ No	
Stroke	□ Yes □ No		Blood Thinners	□ Yes □ No	
Seizures	□ Yes □ No		Glaucoma / Eye Disease	□ Yes □ No	
Emphysema	□ Yes □ No		Hepatitis (type)	□ Yes □ No	
Asthma	□ Yes □ No		Chronic / Recurrent Infections	□ Yes □ No	
Arthritis	□ Yes □ No		Painful/difficult urination	□ Yes □ No	
Diabetes	□ Yes □ No		Change in Appetite	□ Yes □ No	
Thyroid Condition	□ Yes □ No		Weight loss / gain	□ Yes □ No	
Cancer	□ Yes □ No		Weakness / Fatigue	□ Yes □ No	
Gastrointestinal ulcers	□ Yes □ No		Changes in Coordination	□ Yes □ No	
Acid indigestion/reflux	□ Yes □ No		Drug / Alcohol Use	□ Yes □ No	
Change in bowel habits	□ Yes □ No		Emotional Disturbances	□ Yes □ No	
Hearing Loss	□ Yes □ No		Difficulty sleeping	□ Yes □ No	
Headaches	□ Yes □ No		Nausea	□ Yes □ No	
			Vomiting	□ Yes □ No	

PHYSICAL THERAPY QUESTIONARE

1. Have you **ever** had physical therapy before? □ Yes □ No

2. Have you had physical therapy prior to or within our facility **this year**?

   □ Yes □ No If yes, name of outside facility: _____

3. Have you ever had **home health** physical therapy? If yes, when? _____
   how long? _____ name of home health? _____

4. Do you exercise regularly □ Yes □ No

5. How often do you exercise? □ None □ Daily □ ____ times a week

6. What type of exercise? □ walking □ running □ other _____

7. Do you have any of the following problems with exercise? □ chest pain □ dizziness
   □ nausea □ shortness of breath