Rincon Pain and Spine
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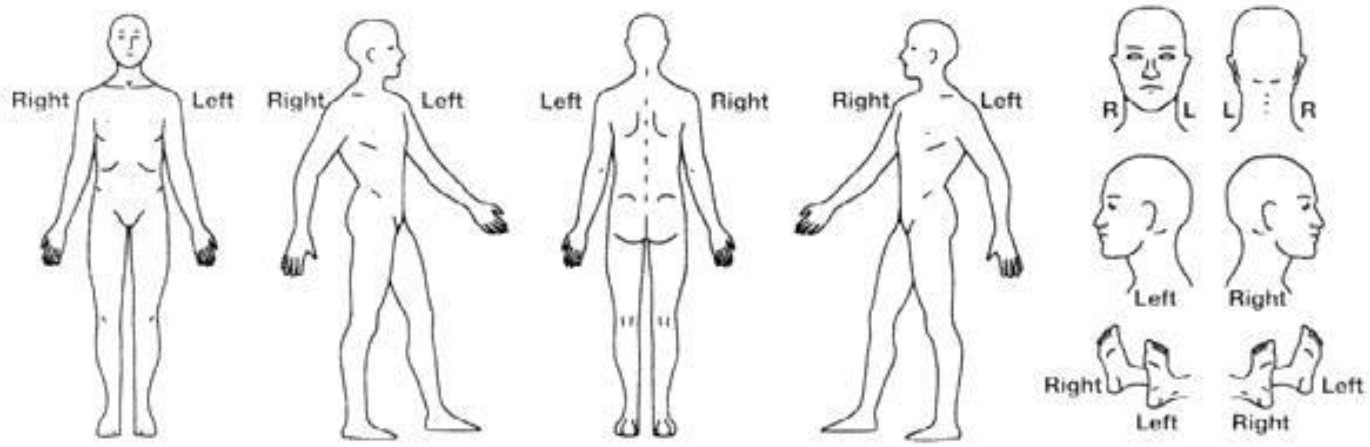
13101 N. Oracle Rd, Ste 193| Oro Valley, AZ 85739

NAME: _____ **DATE OF BIRTH:**_____ **TODAY'S DATE:**_____

Briefly describe your main pain complaint:_____

_____

Please mark the areas with an "X" where you feel pain



When did your pain originally begin?

☐ At work	Date:_____	☐ Motor Vehicle Accident	Date:_____
☐ Following surgery	Date:_____	☐ Illness	Date:_____
☐ Pain just began	Date:_____	☐ Other:_____	Date:_____

How did you get hurt? _____

_____

Pain level today: ____/10 **Lowest pain level: ____/10** **Worst pain level: ____/10**

How often do you have pain?

☐ Constant ☐ Most of the time ☐ Occasionally ☐ Rarely

When is your pain the worst?

☐ No Specific Time ☐ Morning ☐ Afternoon ☐ Evening ☐ Bedtime

Check the boxes that BEST describe your pain?

☐ Numb	☐ Shooting	☐ Radiating	☐ Burning
☐ Sharp	☐ Dull	☐ Electrical	☐ Throb
☐ Pound	☐ Ache	☐ Tingling	☐ Other: _____

Has your pain affected your mood? ☐ No ☐ Yes: (describe)_____

_____

Are there symptoms associated with your pain?

☐ Weakness	☐ Numbness	☐ Vomiting/Nausea	☐ Fatigue
☐ Bowel Incontinence	☐ Urinary Incontinence	☐ Sexual Dysfunction	☐ Hair changes
☐ Color change	☐ Temperature change	☐ Nail changes	☐ Other: _____

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PATIENT LABEL

Which of the following change your pain? (Check all that apply)

	Increases Pain	Decreases Pain		Increases Pain	Decreases Pain		Increases Pain	Decreases Pain
Heat	☐	☐	Bending	☐	☐	Walking	☐	☐
Cold/Ice	☐	☐	Lifting	☐	☐	Staying Busy	☐	☐
Standing	☐	☐	Pushing	☐	☐	Moving Around	☐	☐
Sitting	☐	☐	Tension	☐	☐	Twisting	☐	☐
Sit to stand	☐	☐	Get out of bed	☐	☐	Inactivity	☐	☐
Lying down	☐	☐	Damp Weather	☐	☐	Alcohol	☐	☐
Cough/Sneeze	☐	☐	Gripping	☐	☐	Medication	☐	☐

SLEEP:

Has the pain affected your sleep? ☐ Usually ☐ Occasionally ☐ Rarely

How many hours do you sleep?_____

Do you have trouble falling asleep? ☐ Yes ☐ No

Does your pain awaken you during the night? ☐ Usually ☐ Occasionally ☐ Rarely

TREATMENTS:

Please check any of the following treatments that you have had and how helpful it was:

Modality **POOR – FAIR – GOOD - VERY GOOD OR EXCELLENT RELIEF**

☐ Acupuncture:_____

☐ Chiropractic:_____

☐ Physical therapy:_____

☐ Biofeedback:_____

☐ Counseling/psychotherapy:_____

☐ TENS Unit:_____

☐ Injection therapy:_____

☐ Other:_____

When did you first seek treatment for your pain?_____

List other physicians you have seen for current pain problem:_____

_____

Have you had any tests to evaluate your current pain problem? ☐ **No** ☐ **Yes: List below**

☐ X-rays	Date:_____	☐ Bone Scan	Date:_____
☐ CT Scan	Date:_____	☐ EMG Nerve Test	Date:_____
☐ MRI	Date:_____	☐ Myelogram	Date:_____
☐ Other:_____			Date:_____

PATIENT LABEL

MEDICATIONS:

Please list all medications, vitamins and supplements that you currently take:

Medication Name	Dose	**Frequency** (i.e. 2x per day)

PAST MEDICAL HISTORY:

Please check all that apply

☐ Anemia	☐ Clotting/Bleeding Problem	☐ Hepatitis: _____	☐ Murmur
☐ Angina	☐ COPD	☐ High Blood Pressure	☐ Pacemaker
☐ Arthritis: _____	☐ Depression	☐ HIV	☐ Seizures
☐ Asthma	☐ Diabetes	☐ Irregular Rhythm	☐ Sleep Apnea
☐ Cancer: _____	☐ Emphysema	☐ Kidney Stones	☐ Stroke
☐ Cataracts	☐ GERD	☐ Kidney Disease	☐ Stomach ulcer
☐ Cirrhosis	☐ Heart Attack	☐ Migraines	☐ Thyroid disease
☐ Glaucoma	☐ OTHER: _____		

SURGICAL HISTORY:

Have you ever had <u>any</u> surgery? ☐ No ☐ Yes: If yes, please list below

Procedure:_____ Date:_____ Surgeon:_____

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Procedure:_____ Date:_____ Surgeon:_____

Procedure:_____ Date:_____ Surgeon:_____

Procedure:_____ Date:_____ Surgeon:_____

PAST MENTAL HEALTH HISTORY:

Have you ever <u>had</u> any mental health treatment? ☐ No ☐ Yes (type): _____

Are you <u>currently</u> seeking mental health treatment?
(Psychiatrist, Psychologist, Counselor) ☐ No ☐ Yes(who/where):_____

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ALLERGIES:

Are you allergic to any medications or foods? ☐ No ☐ Yes: List below

Yes	No	Medication/Food/Non-medication	REACTION	SEVERITY (mild/moderate/severe/unknown)
		Iodine		
		Anesthesia		
		Latex		
		Tape/Adhesive		

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Living situation: Who lives in your household?_____

How much caffeine do you consume in 1 day? _____ cups

SMOKING STATUS: ☐ Current every day smoker (Packs per day _____) ☐ Never smoked

☐ Current some day smoker (# of cigarettes _____) ☐ Former smoker: When? _____

☐ Chewing tobacco #_____/day ☐ E-cigarette #_____/day

Do you drink alcohol? (Wine, beer, liquor)

☐ None ☐ Yes: #_____/day/week/month ☐ Quit: When?_____

Have you ever been a recreational or IV drug user, including medical marijuana?

☐ Never ☐ Yes: Type? _____ How long?_____ How often?_____

EMPLOYMENT:

Current occupation:_____

Present employment status: ☐ Full-time ☐ Part-time ☐ Student ☐ Homemaker
☐ Workers Compensation ☐ Unemployed ☐ Leave of Absence ☐ Disability ☐ Retired

If not working, when did you last work? _____

Would you return to work if you had less pain? ☐ No ☐ Yes

Have you found it necessary to seek legal action regarding this pain problem? ☐ Yes ☐ No

Attorney Name/Address:_____

FAMILY HISTORY:

Does your immediate family (parents, siblings) have a history of:

Back Disorder	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Thyroid Disorder	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes	Heart Disease	☐ No	☐ Yes
Cancer	☐ No	☐ Yes	Migraines	☐ No	☐ Yes

Do you have a LIVING WILL? ☐ No ☐ Yes: If yes, please provide us with a copy for your chart.