RINCON PAIN & SPINE

Rincon Pain and Spine
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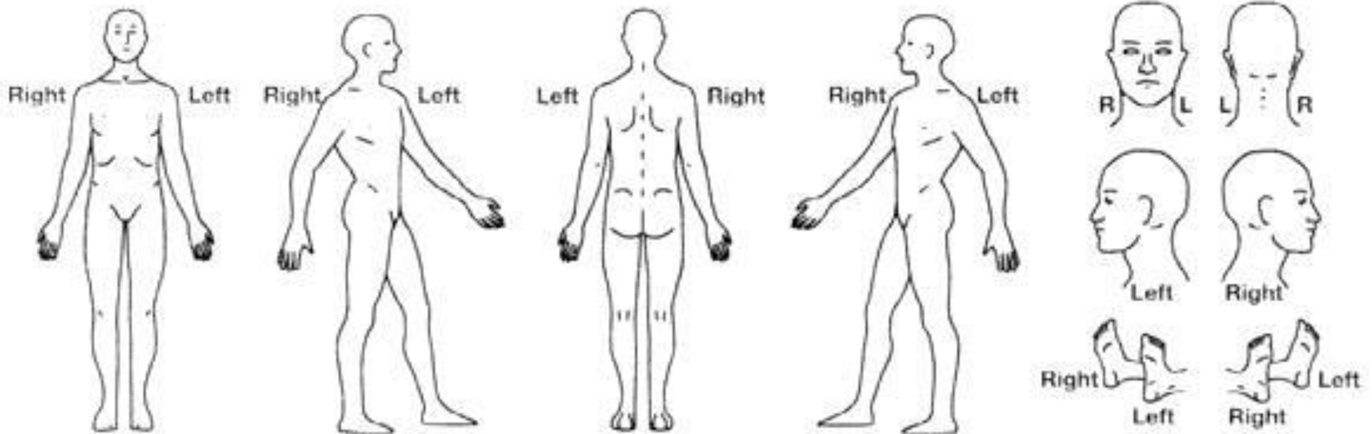
NAME: ______________________________ DATE OF BIRTH:__________ TODAY'S DATE:________________

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

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PATIENT LABEL

☐ Color change ☐ Temperature change ☐ Nail changes ☐ Other: ___________

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:____________

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

SURGICAL HISTORY:

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

Procedure:________________________ Date:____________ Surgeon:____________________

Procedure:________________________ Date:____________ Surgeon:____________________

Procedure:________________________ Date:____________ Surgeon:____________________

Procedure:________________________ Date:____________ Surgeon:____________________

Procedure:________________________ Date:____________ Surgeon:____________________

Procedure:________________________ Date:____________ Surgeon:____________________

PAST MENTAL HEALTH HISTORY:

Have you ever had any mental health treatment? ☐ No ☐ Yes (type): ____________________

Are you currently 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.