PMPJAX.COM
PAIN FREE LIVING

INITIAL OFFICE VISIT PATIENT INFORMATION SHEET

Name: _____ Age: _____ Sex: _____

Referred By: _____ Today's Date: _____

Current Problems

List your chief complaint(s) and/or symptom(s):

1. _____
2. _____
3. _____
4. _____

History of Present Illness

Date of Initial Symptoms:_____

If you answered the accident/personal injury section please skip, otherwise describe in your words:

_____

_____

_____

_____

_____

_____

On the Job/Personal Injury History

Are you being evaluated for pain resulting from a work or personal injury? ☐Yes ☐ No If no, skip to the next section

Date of Accident: _____

Description of accident – (please briefly describe how your injury occurred) _____

_____

_____

When did you first seek care? ☐Immediately ☐Same Day ☐Next Day ☐Other _____

Where did you seek care? ☐Emergency Room ☐Doctor's Office ☐Other_____

What treatment did you initially receive? _____

_____

Place an X next to the number that best describes your pain at its **worst during the last month:**

0	1	2	3	4	5	6	7	8	9	10

Place an X next to the number that best describes your pain on **average during the last month:**

0	1	2	3	4	5	6	7	8	9	10

Pain Description (check all applicable):☐ Constant ☐ Intermittent ☐Sharp ☐Burning ☐ Shooting ☐ Achy ☐Knife-like

☐ Electric ☐ Twisting ☐ Pressure ☐ Lancinating ☐ Buzzing ☐Gnawing ☐Toothache ☐Pressure ☐Deep ☐Heavy

Prior Treatment

Have you been treated by another physician for this? Yes ☐ No ☐ If yes, please list physician(s) name(s):

_____

Please describe previous treatment for the condition that brings you to our office: _____

_____

_____

_____

_____

_____

Have you had any of the following types of therapy? (check all that apply)

☐ Physical Therapy	☐ Epidural Injections
☐ Massage Therapy	☐ Facet Injections
☐ Chiropractic	☐ Other Spinal Injections
☐ Acupuncture	☐ Braces/Supports
☐ Trigger Point Injections	☐ TENS Unit

Activity Limitations

How does your condition affect your daily activities? (Including leisure)_____

_____

_____

_____

Previous Work – Up/Diagnostic Studies

Have you ever had any of the following diagnostic test/work-ups or studies? (check all that apply) If yes: please give the approximate month and year of the study:

☐ X-Rays:	☐ EMG/NCV:
☐ Myelogram:	☐ CAT-SCAN:
☐ EEG:	☐ Bone Scan:
☐ MRI:	☐ Discogram:
☐ Recent Blood Work:	☐ Other(describe):

Past Medical History

List any medical problems past and present which require(d) medical treatment:_____

_____

_____

_____

_____

Have you ever had any surgery? Yes☐ No ☐ If yes, list surgery type and date: _____

_____

_____

Medications

List ALL the medications you are CURRENTLY TAKING:

Name	Dose(mg)	Times per day currently taking
Pain Medications		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Medication other than pain (blood pressure, diabetes, etc.)		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking Plavix/clopidogrel, warfarin, Coumadin, or Effient/prasurgel? Please **write** YES or NO: _____

Are you allergic to shellfish, crabs, iodine, or radiographic dye? Please **write** YES or NO: _____

Are you **allergic** to any medications? Please list if you are:

Medication Allergic to:	**Allergic Reaction**
_____	_____
_____	_____
_____	_____
_____	_____

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

How often do you have mood swings? _____

How often do you smoke a cigarette within an hour after you wake up? _____

How often have you taken medication other than the way that it was prescribed? _____

How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? _____

How often, in your lifetime, have you had legal problems or been arrested? _____

Family History

Are there any members of your family with the same or similar problems or conditions as yours?
Yes ☐ No☐ If yes, please explain:

_____

_____

Personal/Social History

Do you use Tobacco? Yes ☐ No☐ If yes, how Much:_____

Do you use alcohol? Yes☐ No ☐ If yes, amount:_____

Do you have a history of substance abuse (including alcohol)? Yes☐ No ☐ _____

Are you receiving disability benefits from any source? Yes ☐ No ☐ If yes, explain below:

_____

Are you now working? ☐Yes ☐No If yes: ☐Full Time ☐Part Time

What type of work do you perform? _____

_____ Have you had to limit your work because of your condition? ☐Yes ☐ No

Please describe these limitations:_____

_____ If not employed, when were you last employed? ____/____/____. What type of work was that?

_____

Review of Systems (Please circle all that apply to you):

General:	Fever☐ Chills☐ Weight change☐ Weakness☐ Fatigue☐
Ophthalmology:	Blind spots☐ Pain from light☐ Drainage from eye☐ Double vision☐ Blurred vision☐
Respiratory:	Cough☐ Sputum☐ Wheezing☐ Asthma☐ Shortness of breath☐
Cardiology:	High blood pressure☐ Swelling of ankles☐ Murmurs☐ Irregular heartbeat☐ Chest pain☐
Dermatology:	Itching☐ Rash☐ Dry skin☐ Skin color changes☐
Endocrinology:	Diabetes☐ Hyper or Hypo Thyroid☐ Hot/Cold intolerance☐ Frequent urination☐ Thirst☐
Gastrointestinal:	Heartburn☐ Constipation☐ Nausea☐ Vomiting☐ Bloody stools☐ Incontinence of stool☐
Genitourinary:	Incontinence of Urine☐ Bloody urine☐ Burning with urination☐ Kidney Disease☐ Sexual Dysfunction☐
Musculoskeletal:	Pain in: (Low back☐ Mid back☐ Upper back☐ Neck☐ Shoulder☐ Arm☐ Elbow☐ Wrist☐ Hand☐ Hip☐ Leg☐ Knee☐ Ankle☐ Heel☐ Foot☐ Weakness☐ Loss of range of motion☐ Muscle pain☐ Spasms☐ Stiffness☐
Neurology:	Numbness☐ Pins and Needles☐ Seizures☐ Blackouts☐ Dizziness☐ Vertigo☐ Impaired concentration☐ Memory loss☐ Headaches☐ Light/Noise sensitivity☐
Psychology:	Depression☐ Anxiety☐ Panic attacks☐ Difficulty sleeping☐ History of Drug/Alcohol Abuse☐
Hematology:	Swollen glands☐ Bleeding problems☐ Bruising☐ Infection☐ Liver Disease☐

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