momenta
PAIN CARE

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Patient Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone:

Home: _____ Work: _____ Cell: _____

Occupation: _____ Employer: _____

Email Address:
_____

Preferred Contact Method:

Home Work Cell Email

Marital Status:
_____

Race: _____

Ethnicity: Hispanic/LatinoNOT Hispanic/Latino

Preferred Language: English Other: _____

Gender: Male Female

Emergency Contact: _____

Relation: _____ Phone: _____

Are we authorized to discuss your medical care with this person: Yes No

Is this person authorized to make medical decisions on your behalf: Yes No

Signature: _____ Date: _____

S.C._____

Patient Medical History

Name:_____ Date:_____

Referring Physician:_____ Family Physician:_____

DOB:_____ Age:_____ Height:_____ Weight:_____

Date **CURRENT** injury or **SYMPTOMS** began:_____

Is the **CURRENT problem** a result of:
□ work related accident □ motor vehicle accident

If so:
Workman's Comp: □ Yes □ No Litigation: □ Yes □ No

How did the injury occur **OR** symptoms begin ? (Please give a brief explanation)

_____

_____

_____

Have you had any previous problems? □ Yes □ No

If so when?_____

If currently working, is the pain affecting your work? If so, how? _____

Please list any other activities limited by your pain:_____ _____

How would you describe your pain?

□ Continuous	□ Shooting	□ Tiring-Exhausting
□ Intermittent	□ Stabbing	□ Sickening
□ Dull	□ Tender	□ Fearful
□ Aching	□ Gnawing	□ Punishing-Cruel
□ Heavy	□ Pressure	□
□ Throbbing	□ Burning/Hot	□
□ Sharp	□ Cramping	□

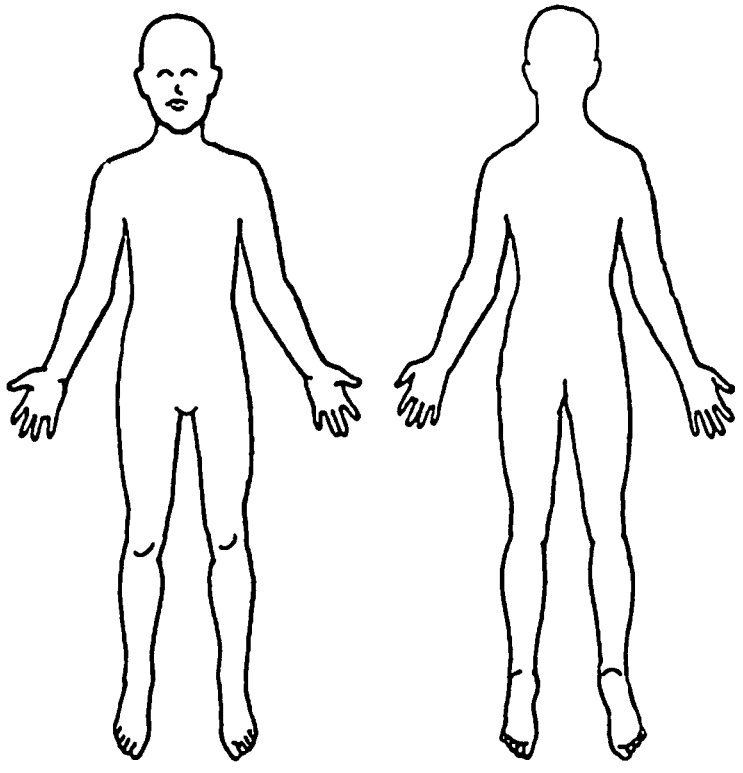
Rate your pain: 0= No Pain 10=Worst pain imaginable

Current:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10

How do the following activities affect your pain?

	Better	Worse	No Change
Resting	____	____	____
Lying down	____	____	____
Sitting	____	____	____
Standing	____	____	____
Bending	____	____	____
Walking	____	____	____
Changing positions	____	____	____
Working	____	____	____
Coughing/Sneezing/Straining	____	____	____
Lifting	____	____	____
Prolonged Position	____	____	____

Please draw the location of your pain:



Are you experiencing?
□ Numbness/Tingling Where:_____
□ Weakness

Are you experiencing?
□ Loss of bowel/bladder control Explain:_____

Are you experiencing any of the following related to your pain?
□ Sleep Disturbance
□ Anxiety
□ Depression

TREATMENT:
□ I have had no treatment for my symptoms to date.

PAIN MEDICATIONS USED:
□ I have not tried any medications including over the counter medications.
If so, medications tried include:

NSAIDS	Helped	No Help		Helped	No Help		Helped	No Help
Advil			Flexeril			Ultram (tramadol)		
Aleve			Skelaxin			Hydrocodone		
Aspirin			Soma			Vicodin		
Cataflam			Vistaril			Tylenol w/ Codeine		
Celebrex			Zanaflex			Tylox		
Daypro			**********			Percocet		
Feldene			Amitriptyline			Oxycontin		
Ibuprofen			Cymbalta			Fentanyl		
Indocin			Elavil			Kadian		
Lodine			Paxil			Avinza		
Mobic			Prozac			Morphine		
Motrin			Wellbutrin			Duragesic		
Relafen			Zoloft			Methadone		
Voltaren			**********			**********		
**********			Lyrica			Prednisone		
Tylenol			Neurontin			Medrol Dosepak		
						Other:		

PHYSICAL THERAPY:
□ I have not had physical therapy.
Facility :_____ Dates of physical therapy:_____
If so, methods tried include:

□ Exercise □ Ice □ Electrical Stimulation
□ Massage □ Heat □ TENS Unit
□ Ultrasound □ Traction □ Whirlpool

Physical Therapy provided:

□ No Relief □ Mild Relief □ Significant but temporary relief □ Significant withstanding relief □ Made symptoms worse

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CHIROPRACTICS:
□ I have not tried any chiropractic care.
Name of Chiropractor: _____ Dates of chiropractic visits:_____
If so, methods tried include:

□ Manipulation □ Electrical Stimulation □ Acupuncture □ Massage □ X-Rays

Chiropractics provided:

□ No Relief □ Mild Relief □ Significant but temporary relief □ Significant withstanding relief □ Made symptoms worse

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BACK BRACE:
□ I have not tried a back brace. □ Have used a lumbar brace. □ Have used a cervical collar
If so, back brace provided:

□ No relief □ Mild relief □ Significant but temporary relief □ Significant withstanding relief □ Made symptoms worse

Pain Clinic:
□ I have not been treated by another pain physician or clinic.

Facility/Physician:_____ **Dates:**_____

Brief Description of Therapy:_____

_____

Psychological/ Behavioral Therapy:
□ I have not been treated for psychological health.

Facility/Physician:_____ **Dates:**_____

Brief Description of Therapy:_____

STEROID INJECTIONS:
□ I have not had any injections.

RESULTS OF INJECTION

Date	Location: (i.e. low back, neck)	Physician/ CRNA done by:	X-Ray guided:	No Relief	Mild Relief	Significant but temporary relief	Significant withstanding relief	Made Symptoms Worse

SPINE SURGERY:
□ I have not had any surgery on my spine.

RESULTS OF SURGERY

Date	Location: (i.e. low back, neck)	Physician:	Reason for Surgery:	No Relief	Mild Relief	Significant but temporary relief	Significant withstanding relief	Made Symptoms Worse

DIAGNOSTIC TESTS/ IMAGING:
□ I have not had any diagnostic studies.
□ X-Rays– Date:_____ □ MRI– Date:_____ □ CT– Date_____ □ EMG– Date_____ □Myelogram_____

CURRENT MEDICATIONS: **PLEASE LIST ALL**

Medication Name:	Dose:	Frequency:

PAST/CURRENT MEDICAL CONDITIONS:

- ◻ None
- ◻ Migraines/Headaches
- ◻ Parkinson's Disease
- ◻ Stroke
- ◻ High Blood Pressure
- ◻ High Cholesterol
- ◻ Heart Disease:_____
- ◻ Blood Clots-When_____
- ◻ Blocked Arteries– Where:_____
- ◻ Asthma
- ◻ COPD/Emphysema
- ◻ Pulmonary Disease
- ◻ Sleep Apnea
- ◻ GERD/ Acid Reflux
- ◻ Peptic Ulcer Disease
- ◻ Inflammatory Bowel Disease
- ◻ Hepatitis
- ◻ Cirrhosis
- ◻ Diabetes
- ◻ Thyroid Disease/Goiter
- ◻ Prostate Problems
- ◻ Kidney Disease
- ◻ Cancer:_____
- ◻ Arthritis
- ◻ Depression/Bi-polar
- ◻ Anxiety
- ◻ Other:_____

SURGICAL HISTORY:

SURGERY/ HOSPITALIZATIONS:	DATE:

Anesthesia Complications: ◻ No ◻ Yes:_____

ALLERGIES:

◻ I have no known medication allergies.

Medication Allergies:	Reaction:
◻ Penicillins	_____
◻ Sulfa	_____
◻ Codeine	_____
◻ Morphine	_____
◻ Aspirin	_____
◻ Other	_____

FAMILY HISTORY:

◻ Unknown ◻ No known significant family history of heart disease, cancer, or other serious illness.

Mother:	◻ Living	◻ Deceased	Health Problems:_____
Father:	◻ Living	◻ Deceased	Health Problems:_____
Brother:	◻ Living	◻ Deceased	Health Problems:_____
Sister:	◻ Living	◻ Deceased	Health Problems:_____
Children:	◻ Living	◻ Deceased	Health Problems:_____

SOCIAL HISTORY:

Education: ◻ Elementary School ◻ GED ◻ High School Diploma ◻ Some College ◻ College Degree ◻ Trade School

Occupation:_____ Employer:_____

Are you currently working? ◻Yes ◻ No ◻ Retired ◻ Disabled

Marital Status: ◻ Single ◻ Married ◻ Divorced ◻ Separated ◻ Widowed ◻ Children:_____

Tobacco Use: ◻ No ◻ Yes Amount:_____

Alcohol Use: ◻ No ◻ Yes Amount:_____

Illicit Drug Use: ◻ No ◻ Yes Amount:_____

REVIEW OF SYSTEMS: Please check any of the following symptoms that you are experiencing currently.

Review of Systems:				
CONSTITUTIONAL:	◻ Fever ◻ Weight gain	◻ Chills ◻ Decreased energy	◻ Night sweats ◻ Loss of appetite	◻ Weight loss
HEENT:	◻ Runny nose ◻ Vision changes	◻ Nose bleeds	◻ Sinus congestion	◻ Hearing loss
SKIN:	◻ Rash	◻ Non-healing skin lesions	◻ Abnormal Pigmentation/ Vitiligo	
NEUROLOGIC:	◻ Seizure disorder ◻ Paralysis	◻ Tremors ◻ Weakness in extremity	◻ Dizziness/Fainting ◻	◻ Loss of balance
CARDIAC:	◻ Chest pain/Angina ◻ Swelling in extremities	◻ Heart Palpitations ◻	◻ Shortness of breath	◻ Rapid heart rate
RESPIRATORY:	◻ Wheezing ◻ Blood stained sputum	◻ Cough	◻ Upper respiratory infection	◻ Sleep apnea
GASTROINTESTINAL:	◻ Abdominal pain ◻ Diarrhea	◻ Vomiting ◻ Bloody stools	◻ Heartburn	◻ Constipation
HEPATIC:	◻ Hepatitis	◻ Jaundice	◻ Cirrhosis	
ENDOCRINE:	◻ Diabetes problems ◻ Excessive thirst	◻ Thyroid problems ◻ Excessive urination	◻ Heat intolerance	◻ Cold intolerance
GENITOURINARY:	◻ Urinary incontinence ◻ Post-menopausal	◻ Pain with urination ◻ Urinary tract infection	◻ Prostate problems ◻ Blood in urine	◻ Post-hyster ◻ Kidney stones
HEMATOLOGIC:	◻ Anemia	◻ Easy bruising/bleeding	◻ Swollen lymphnodes	
MUSCULOSKELETAL:	◻ Joint pain ◻ Joint restriction	◻ Back pain	◻ Neck pain	◻ Muscle pain
PSYCHIATRIC:	◻ Stress ◻ Anxiety	◻ Depression	◻ Sleep disturbance	◻ Mood changes
IMMUNOLOGIC:	◻ HIV/AIDS			

Physical Exam:					
General:	WNL				
Psych:	WNL				
Skin:	WNL	Rash	Tattoo		
HEENT:	WNL	Dentures			
Neck:	WNL				
Heart:	WNL	Bradycardia	Tachycardia	Irregular	Murmur
Lungs:	WNL	Wheezes	Rales	Rhonchi	
Abdomen:	WNL	Obese	Tender		
Extremities:	WNL				

Lumbar Inspection:	ROM:	Palpation:	Neuro:	Sensory:	Motor:	DTR:
WNL	Flexion: + - 0____90	LmbParaMusc: R L B	Station:	L3: WNL DS: R L B	Hip Flexor: 5____0 R L	Patellar: Rt:0 1 2 3 4 5 Lt: 0 1 2 3 4 5
Scar: Lumbar Thoracic	Extension: + - 0____90	Trigger Points: R L B	Gait:	L4: WNL DS: R L B	Quadriceps: 5____0 R L	Achilles: Rt:0 1 2 3 4 5 Lt: 0 1 2 3 4 5
Scoliosis	Facet Loading: R L B	SI Joint: R L B	Heels/Toes:	L5: WNL DS: R L B	Ankle Inversion: 5____0 R L	
Kyphosis	St. Leg Raising Exam: R L B		Hoffman's Sign:	S1: WNL DS: R L B	Ankle Eversion: 5____0 R L	
Lordosis	Patrick's Test: R L B				EHL: 5____0 R L	
					Gastrocnemius: 5____0 R L	

Cervical Inspection:	ROM:	Palpation:	Sensory:	Motor:	DTR:
WNL	Flexion: + - 0____90	CrvParaMusc: R L B	C5: WNL DS: R L B	Deltoids: 5____0 R L	Biceps: Rt:0 1 2 3 4 5 Lt: 0 1 2 3 4 5
Scar: Cervical	Extension: + - 0____90	Trigger Points: R L B	C6: WNL DS: R L B	Biceps: 5____0 R L	Triceps: Rt:0 1 2 3 4 5 Lt: 0 1 2 3 4 5
Shoulders: R>L L>R	Facet Loading: R L B		C7: WNL DS: R L B	Wrist Extensors: 5____0 R L	Brachioradialis: Rt:0 1 2 3 4 5 Lt: 0 1 2 3 4 5
			C8: WNL DS: R L B	Triceps: 5____0 R L	
			T1: WNL DS: R L B	Grip Strength: 5____0 R L	

IMPRESSION:_____ PLAN:_____

_____

Peter N. Piperis MD