DESERT SKY
SPINE & PAIN
FOCUSED ON FUNCTION

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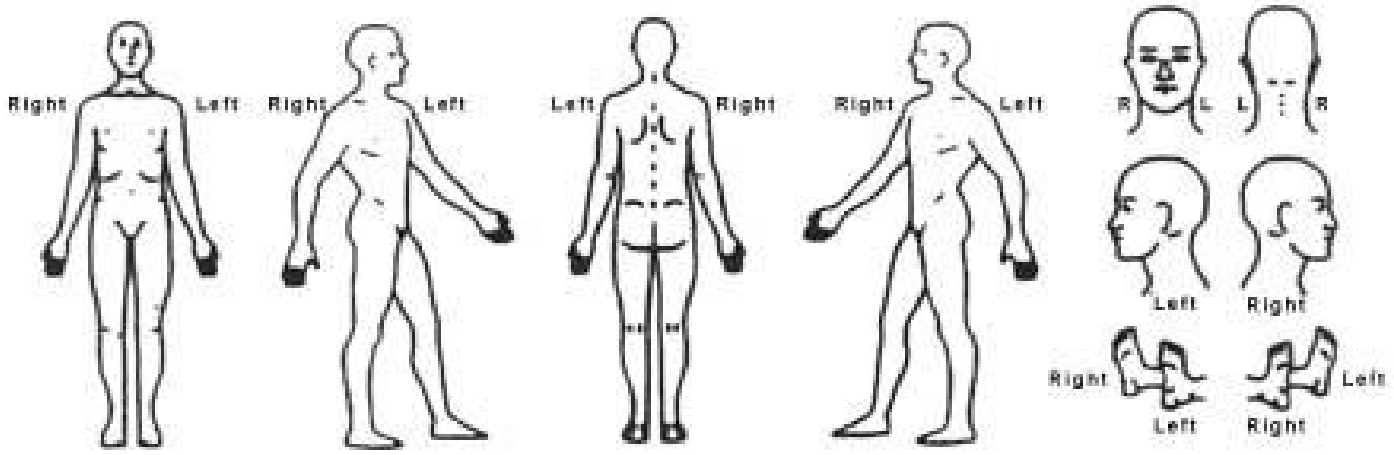
**NAME:** _____ **DOB:** _____ **TODAY'S DATE:** _____

**Briefly describe your main pain concern:** _____

_____

Use **X**'s to mark where you feel your pain on the diagrams below:




**When did your pain originally begin?**

| | | | |
|---|---|---|---|
| ○ At Work | Date: _____ | ○ Motor Vehicle Accident | Date: _____ |
| ○ Following Surgery | Date: _____ | ○ Illness | Date: _____ |
| ○ Pain Began Suddenly | Date: _____ | ○ Other: _____ | Date: _____ |

**What caused your injury?** _____

_____

**Lowest Pain Level**: ___/10 **Worst Pain Level**: ___/10 **Pain Level Today**: ___/10

**How often does your pain occur?**

○ Rarely ○ Occasionally ○ Most of the Time ○ Constantly

**When is your pain the worst?**

○ No specific time ○ Morning ○ Afternoon ○ Evening

**Choose what best describe your pain:**

| | | | |
|---|---|---|---|
| ○ Numb | ○ Shooting | ○ Radiating | ○ Burning |
| ○ Sharp | ○ Dull | ○ Electrical | ○ Throbbing |
| ○ Pounding | ○ Aching | ○ Tingling | ○ Other: _____ |

**Has the pain affected your mood? If yes, please describe:** _____

_____

**Please indicate any 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: _____ |

**Which of the following increases or decreases your pain level?**

| | Increases | Decreases | | Increases | Decreases | | Increases | Decreases |
|---|---|---|---|---|---|---|---|---|
| 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 | ○ | ○ |

**Has the pain affected your sleep?**

○ Usually ○ Occasionally ○ Rarely

**How many hours do you sleep per night?**

○ Less than 6 ○ 6 to 10 ○ More than 10

**Do you have trouble falling asleep?**

○ Usually ○ Occasionally ○ Rarely

**Does your pain wake you during your sleep?**

○ Usually ○ Occasionally ○ Rarely

**Please check any of the following treatment modalities you have had and how it has helped:**

| | Poor | Fair | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| Acupuncture | ○ | ○ | ○ | ○ | ○ |
| Chiropractor | ○ | ○ | ○ | ○ | ○ |
| Physical Therapy | ○ | ○ | ○ | ○ | ○ |
| Biofeedback | ○ | ○ | ○ | ○ | ○ |
| Counseling | ○ | ○ | ○ | ○ | ○ |
| Psychotherapy | ○ | ○ | ○ | ○ | ○ |
| Injection Therapy | ○ | ○ | ○ | ○ | ○ |
| TENS Unit | ○ | ○ | ○ | ○ | ○ |
| Other: _____ | ○ | ○ | ○ | ○ | ○ |

**When did you initially seek treatment for your pain?** _____

_____

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

_____

**Have you had any diagnostic tests done to evaluate your pain?**

| | | | |
|---|---|---|---|
| ○ X-rays | Date: _____ | ○ Bone Scan | Date: _____ |
| ○ CT Scan | Date: _____ | ○ EMG/NCV | Date: _____ |
| ○ MRI | Date: _____ | ○ EEG | Date: _____ |
| ○ Genetic Testing | Date: _____ | ○ Myelogram | Date: _____ |
| ○ Other: _____ | Date: _____ | ○ Other: _____ | Date: _____ |

**Please list any medications, supplements or vitamins you are currently taking or provide a list to us:**

| Medication Name | Strength | How Many | How Often |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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**Past Medical History:** Please check all that apply

| | | | |
|---|---|---|---|
| ○ Anemia | ○ Clotting/Bleeding Disorder | ○ Hepatitis | ○ Murmur |
| ○ Angina | ○ COPD | ○ High Blood Pressure | ○ Pacemaker |
| ○ Arthritis | ○ Depression | ○ HIV | ○ Seizures |
| ○ Asthma | ○ Diabetes | ○ Irregular Heart Rhythm | ○ Sleep Apnea |
| ○ Cancer | ○ Emphysema | ○ Kidney Disease | ○ Stroke |
| ○ Cataracts | ○ GERD | ○ Kidney Stones | ○ Stomach Disorder |
| ○ Cirrhosis | ○ Heart Attack | ○ Migraines | ○ Thyroid Disease |
| ○ Glaucoma | ○ Other: _____ | ○ Other: _____ | ○ Other: _____ |

**Past Surgical History:** List any past surgeries or procedures

| Surgery/Procedure | Date | Surgeon |
|---|---|---|
| | | |
| | | |
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| | | |

**Allergies:** Please list any allergies, the reaction and the severity of the reaction, or check "No Known Allergies"

○ No Known Allergies

| Medication Name | Reaction | Severity (Mild/Moderate/Severe) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Social History:**

**Martial Status**: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

**Living Situation**: ○ Alone ○ With Others: _____

**Caffeine Consumption per Day**: ○ None ○ _____ cups

**Smoking Status**: ○ Current Every Day Smoker – Packs per Day _____ ○ Never Smoked

○ Current Some Day Smoker – Cigarettes per Week _____ ○ Former Smoker – Quit _____

○ Chewing Tobacco – Times per Day _____ ○ E-Cigarette – Times per Day _____

**Alcohol Consumption:** ○ Never ○ _____ drinks per day/week/month ○ Quit _____

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

○ Never ○ Current ○ Quit _____ Type _____ How Long? _____ How Often? _____

**Employment:** Current Occupation: _____

Employment Status: ○ Full-Time ○ Part-Time ○ Student ○ Homemaker

○ Worker's Comp ○ Unemployed ○ Leave of Absence ○ Disability ○ Retired

**If not currently working, when did you last work?** _____

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

Have you or do you find it necessary to seek legal action regarding your current pain? ○ Yes ○ No

Attorney Name: _____ Address: _____ Phone: _____

**Family History:** Please check all that apply to immediate family members only and their relation to you

○ Back Disorder _____ ○ Diabetes _____

○ Thyroid Disorder _____ ○ Stroke _____

○ High Blood Pressure _____ ○ Heart Disease _____

○ Cancer _____ ○ Migraines _____

**Do you have a living will or power of attorney?** ○ No ○ Yes (Please provide us with a copy)

**Your Contact Information:** Email Address: _____ Preferred Phone #: _____

**Emergency Contact:** Name: _____ Relation to You: _____ Phone #: _____

**Primary Care:** Name: _____ Location: _____ Phone #: _____

**Referring Provider:** Name: _____ Location: _____ Phone #: _____