

Triad Pain Management Clinic
Patient Health History - Intake Form

Can you describe the sensation you feel? (eg. Shooting, Burning, Throbbing, etc.)

Does it radiate to any other part of your body? Yes No If yes, describe:

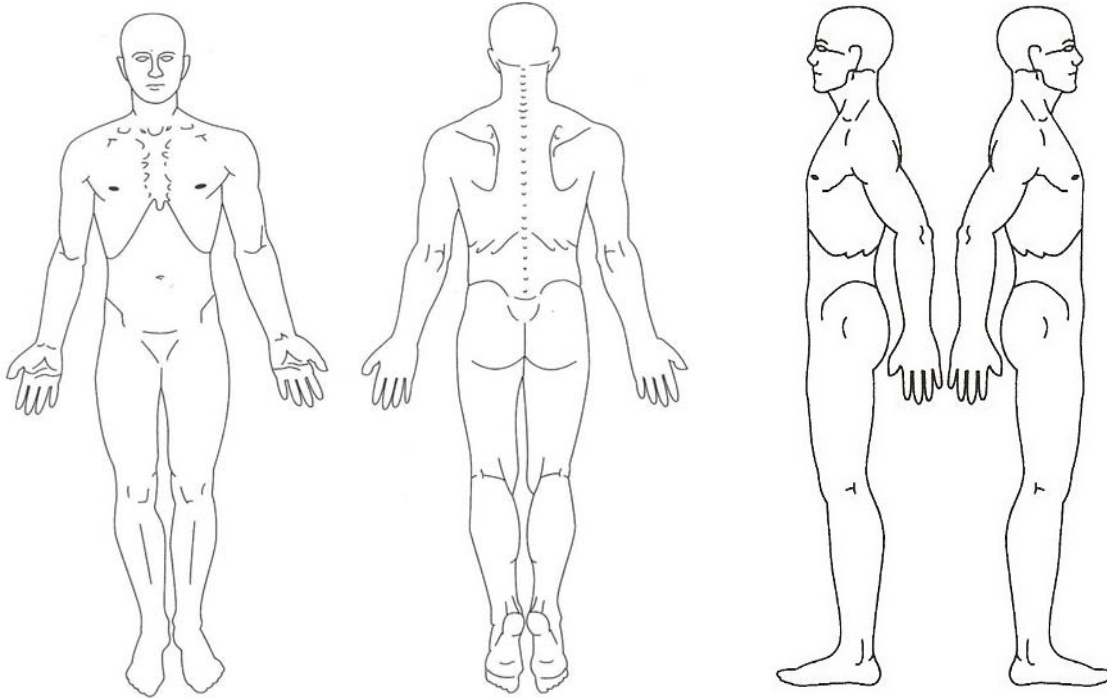
Has your current pain? Better Worse Unchanged

What makes it worse? (eg. Sitting, Standing, Bending, Work, etc.)

What makes it better? (eg. Rest, Medication, Exercise, Treatment, etc.)

Doctor Notes

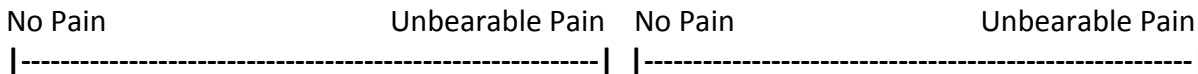
PLEASE DRAW THE LOCATION OF YOUR PAIN USING THE SYMBOLS SHOWN BELOW
D = Dull, B = Burning, N = Numb, S = Stabbing, T = Tingling, C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

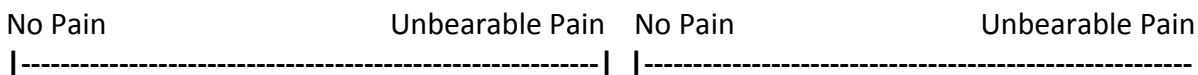
Rate the pain you have right **now**:

Rate your pain at its **best** in the past week:



Rate your **average** pain in the past week:

Rate your **worst** pain in the past week:



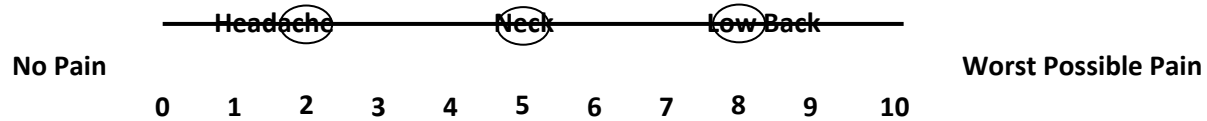
DR. INITIALS

QUADRUPLE VISUAL ANALOGUE SCALE:

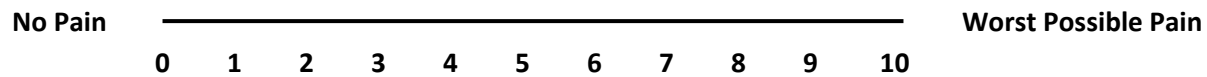
Instructions: Please circle the number that best describes the question being asked

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

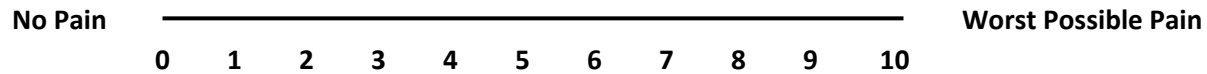
Example:



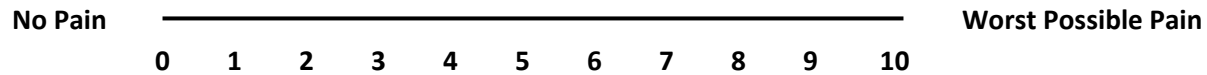
1 – WHAT IS YOUR PAIN RIGHT NOW?



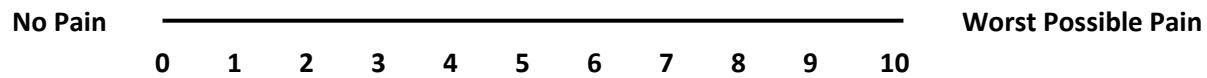
2 – WHAT IS YOUR TYPICAL OR AVERAGE PAIN?



3 – WHAT IS YOUR PAIN LEVEL AT ITS BEST? (How close to “0” does your pain get at its best?)



4 – WHAT IS YOUR PAIN LEVEL AT ITS WORST? (How close to “10” does your pain get at its worst?)



HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING:

- Bladder/Bowel Incontinence
- Nausea/ Vomiting
- Blurred Vision
- Weight Loss
- Kidney Pain/ Painful Urination
- Bowel Incontinence
- Dizziness/ Balance Problems
- Excessive Fatigue-Malaise
- Weakness Yes No, Where? _____
- Other (Describe): _____
- Fever/ Chills
- Night Pain/ Sweats
- Ovarian/ Abdominal Pain

Doctor Notes

DR. INITIALS

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HAVE YOU TRIED OTHER TREATMENTS FOR THIS CONDITION?

Yes No, If yes indicate Improvement Rating: **1 = Better 2 = No Change 3 = Worse**

- | | | |
|---|------------------------|---------------------------|
| <input type="checkbox"/> Chiropractic: | Weeks/Months: _____ | Improvement Rating: _____ |
| <input type="checkbox"/> Physical Therapy: | Weeks/Months: _____ | Improvement Rating: _____ |
| <input type="checkbox"/> Acupuncture: | Weeks/Months: _____ | Improvement Rating: _____ |
| <input type="checkbox"/> Yoga/Exercise: | Weeks/Months: _____ | Improvement Rating: _____ |
| <input type="checkbox"/> Trigger Point Injections: | Number/Times: _____ | Improvement Rating: _____ |
| <input type="checkbox"/> Facet Joint Injections: | Number/Times: _____ | Improvement Rating: _____ |
| <input type="checkbox"/> Epidural Injections: | Number/Times: _____ | Improvement Rating: _____ |
| <input type="checkbox"/> Joint Injections: | Number/Times: _____ | Improvement Rating: _____ |
| <input type="checkbox"/> Surgery: | Date(s)/Area(s): _____ | Improvement Rating: _____ |
| <input type="checkbox"/> Radiofrequency/Ablations: | Date(s)/Area(s): _____ | Improvement Rating: _____ |
| <input type="checkbox"/> Over-the-counter Meds/Brand: _____ | | Improvement Rating: _____ |
| <input type="checkbox"/> Prescription Meds/Brand: _____ | | Improvement Rating: _____ |
| <input type="checkbox"/> Vitamins/Herbs: _____ | | Improvement Rating: _____ |

PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN

Please indicate all doctors from first to last that you have attended after your injury or condition began. Please check all boxes that apply.

1) Hospital/ Doctor/ Therapist/ Center Seen: _____		
Address: _____	Phone: _____	Date: _____
Indicate What Was Done:		
<input type="checkbox"/> Exam-consultation	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Exercises
<input type="checkbox"/> Exam (no treatment)	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> X-ray of neck or head	<input type="checkbox"/> Spinal adjustments	<input type="checkbox"/> Injection(s)
<input type="checkbox"/> X-ray of chest/ribs/middle back	<input type="checkbox"/> Muscle massage/myotherapy	<input type="checkbox"/> Wrist brace-splint
<input type="checkbox"/> X-ray of low back/pelvis/hips	<input type="checkbox"/> Muscle stimulation	<input type="checkbox"/> Neck collar (brace)
<input type="checkbox"/> X-ray of shoulder/arm/leg	<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Low back brace
<input type="checkbox"/> MRI/CT scan	<input type="checkbox"/> Anti-inflammatory medication	<input type="checkbox"/> Heat packs
<input type="checkbox"/> EMG/Nerve conduction study	<input type="checkbox"/> Pain medications	<input type="checkbox"/> Ice packs
<input type="checkbox"/> Other tests: _____	<input type="checkbox"/> Muscle relaxants	<input type="checkbox"/> Other: _____
Treatment with this provider: <input type="checkbox"/> Helped <input type="checkbox"/> Did Not Help <input type="checkbox"/> Made Condition Worse		

Doctor Notes

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Doctor Notes

2) Hospital/ Doctor/ Therapist/ Center Seen:

Address: _____ **Phone:** _____ **Date:** _____

Indicate What Was Done:

- | | | |
|--|---|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Exercises |
| <input type="checkbox"/> Exam (no treatment) | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> X-ray of neck or head | <input type="checkbox"/> Spinal adjustments | <input type="checkbox"/> Injection(s) |
| <input type="checkbox"/> X-ray of chest/ribs/middle back | <input type="checkbox"/> Muscle massage/myotherapy | <input type="checkbox"/> Wrist brace-splint |
| <input type="checkbox"/> X-ray of low back/pelvis/hips | <input type="checkbox"/> Muscle stimulation | <input type="checkbox"/> Neck collar (brace) |
| <input type="checkbox"/> X-ray of shoulder/arm/leg | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Low back brace |
| <input type="checkbox"/> MRI/CT scan | <input type="checkbox"/> Anti-inflammatory medication | <input type="checkbox"/> Heat packs |
| <input type="checkbox"/> EMG/Nerve conduction study | <input type="checkbox"/> Pain medications | <input type="checkbox"/> Ice packs |
| <input type="checkbox"/> Other tests: _____ | <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Other: _____ |

Treatment with this provider: Helped Did Not Help Made Condition Worse

3) Hospital/ Doctor/ Therapist/ Center Seen:

Address: _____ **Phone:** _____ **Date:** _____

Indicate What Was Done:

- | | | |
|--|---|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Exercising |
| <input type="checkbox"/> Exam (no treatment) | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> X-ray of neck or head | <input type="checkbox"/> Spinal adjustments | <input type="checkbox"/> Injection(s) |
| <input type="checkbox"/> X-ray of chest/ribs/middle back | <input type="checkbox"/> Muscle massage/myotherapy | <input type="checkbox"/> Wrist brace-splint |
| <input type="checkbox"/> X-ray of low back/pelvis/hips | <input type="checkbox"/> Muscle stimulation | <input type="checkbox"/> Neck collar (brace) |
| <input type="checkbox"/> X-ray of shoulder/arm/leg | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Low back brace |
| <input type="checkbox"/> MRI/CT scan | <input type="checkbox"/> Anti-inflammatory medication | <input type="checkbox"/> Heat packs |
| <input type="checkbox"/> EMG/Nerve conduction study | <input type="checkbox"/> Pain medications | <input type="checkbox"/> Ice packs |
| <input type="checkbox"/> Other tests: _____ | <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Other: _____ |

Treatment with this provider: Helped Did Not Help Made Condition Worse

4) Hospital/ Doctor/ Therapist/ Center Seen:

Address: _____ **Phone:** _____ **Date:** _____

Indicate What Was Done:

- | | | |
|--|---|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Exercises |
| <input type="checkbox"/> Exam (no treatment) | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> X-ray of neck or head | <input type="checkbox"/> Spinal adjustments | <input type="checkbox"/> Injection(s) |
| <input type="checkbox"/> X-ray of chest/ribs/middle back | <input type="checkbox"/> Muscle massage/myotherapy | <input type="checkbox"/> Wrist brace-splint |
| <input type="checkbox"/> X-ray of low back/pelvis/hips | <input type="checkbox"/> Muscle stimulation | <input type="checkbox"/> Neck collar (brace) |
| <input type="checkbox"/> X-ray of shoulder/arm/leg | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Low back brace |
| <input type="checkbox"/> MRI/CT scan | <input type="checkbox"/> Anti-inflammatory medication | <input type="checkbox"/> Heat packs |
| <input type="checkbox"/> EMG/Nerve conduction study | <input type="checkbox"/> Pain medications | <input type="checkbox"/> Ice packs |
| <input type="checkbox"/> Other tests: _____ | <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Other: _____ |

Treatment with this provider: Helped Did Not Help Made Condition Worse

DR. INITIALS

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Do you have any secondary pain or issues concerning you? Yes No If yes, please describe:

SOCIAL HISTORY:

FAMILY:

<input type="checkbox"/> Married/ Living With Significant Other <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single	
Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, How many? _____ How old? _____	
Do any of your children live at home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, How many? _____	

SOCIAL:

Do you drink Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, How many per day? _____	Do you drink Caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, How many per day? _____
Do you use Tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, How many per day? _____	Do you use Illegal Drugs? ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, How much & when? _____

EXERCISE:

<input type="checkbox"/> I do no exercise regularly	<input type="checkbox"/> I exercise 1-2 times a week	<input type="checkbox"/> I exercise 3-5 times a week
<input type="checkbox"/> I stretch regularly	<input type="checkbox"/> I do weight lifting at gym/ home	<input type="checkbox"/> I do cardiovascular work outs
<input type="checkbox"/> I am willing to exercise	<input type="checkbox"/> I am not will to exercise	<input type="checkbox"/> I do regular sports activities

Hand Dominance? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ambidextrous	Served in Military? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Branch & Dates _____
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OCCUPATIONAL HISTORY:

Are you currently employed? Yes No If yes, please describe:

What is your Job / Profession? _____

Job Description / Duties: _____

Does your pain affect you from performing job duties? Yes No If yes, please describe:

Doctor Notes

DR. INITIALS

Triad Pain Management Clinic
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Doctor Notes

PAST MEDICAL HISTORY:

NOTE: If you have ever had a listed symptom in the past or presently, please indicate below.
Knowledge of these conditions may influence the type of treatment/therapy you receive.

<u>PAST</u>	<u>PRESENT</u>	<u>CONDITION</u>	<u>PAST</u>	<u>PRESENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gallbladder Problem
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain _____	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Muscular In-Coordination
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain (R/L)
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Irregular Bowel	<input type="checkbox"/>	<input type="checkbox"/>	Lower Leg/Knee Pain (R/L)
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Upper Leg/Knee Pain (R/L)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/ Eczema/ Rash	<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (Lung Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain (R / L)
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Stroke (Date _____)
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Swelling Stiffness of Joints
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises)
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (R / L)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Upper Arm Pain (R / L)
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/ Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain (R / L)
<input type="checkbox"/>	<input type="checkbox"/>	Other _____			

DR. INITIALS

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Doctor Notes

GENERAL QUESTIONS:

NOTE: Check only those conditions that apply to you and indicate if you have had any in the past or presently have.

<u>YES</u>	<u>GENERAL QUESTIONS</u>	<u>PAST</u>	<u>PRESENT</u>
<input type="checkbox"/>	History of poor healing?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Intolerance to heat or ice packs?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy/ Seizure/ Convulsion history?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of any nerve diseases?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of any strokes?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have scoliosis, spondylolisthesis, spina bifida, fused vertebrae?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have bulging/ herniated disks?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of AIDS, Tuberculosis, ALS, Meningitis, etc?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of blood clots, bleeding, vascular disorder, anemia?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have weak bones, osteoporosis, osteopenia?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have arthritis, degeneration, or rheumatoid arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of autoimmune, chrohns, muscle diseases?	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN ONLY:

- Do you currently have any type of chest or breast implants? N / A
- Are there any chances that you are currently pregnant? N / A

Number of Births: _____ Number of C-Sections: _____ Number of Miscarriages? _____

PRIOR INJURY OR PREVIOUS MUSCULOSKELITAL PAIN:

Please check all that apply. (I have **NO** history of previous painful injury or pain)

- | | | | | |
|--|--------------------------------------|---|--|--|
| <input type="checkbox"/> Work Injury | <input type="checkbox"/> Fall | <input type="checkbox"/> Home Injury | <input type="checkbox"/> Lifting Injury | <input type="checkbox"/> Car Accident |
| <input type="checkbox"/> Motorcycle Injury | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Pedestrian Injury | <input type="checkbox"/> Military Injury | <input type="checkbox"/> Other Injury |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Middle Back Pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Arm Numb/Tingling | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Leg Pain/ Tingling | <input type="checkbox"/> Sports Injury | <input type="checkbox"/> Other Pain: _____ |

Please list past injury / trauma: _____

FRACTURES / BROKEN BONES HISTORY:

Please check all that apply. (I have **NO** history of broken bones)

<u>REGION</u>	<u>YEAR</u>	<u>REGION</u>	<u>YEAR</u>
<input type="checkbox"/> Spinal Vertebra	_____	<input type="checkbox"/> Skull	_____
<input type="checkbox"/> Collar bone, ribs, or sternum	_____	<input type="checkbox"/> Pelvis or hip bones	_____
<input type="checkbox"/> Arm, leg, hand or foot bones	_____	<input type="checkbox"/> Other: _____	_____

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PREVIOUS SURGERIES:

Please check all that apply. (I have **NEVER** had any surgical procedures)

<u>SURGERY</u>	<u>YEAR</u>	<u>SURGERY</u>	<u>YEAR</u>
<input type="checkbox"/> Spine surgery (neck,back,pelvis)	_____	<input type="checkbox"/> Abdominal/ Chest/ Appendix	_____
<input type="checkbox"/> Disc surgery in neck or back	_____	<input type="checkbox"/> Gallbladder/Liver/Stomach/ Kidney	_____
<input type="checkbox"/> Heart	_____	<input type="checkbox"/> Cancer (any type)	_____
<input type="checkbox"/> Head/ Brain/ Spinal Cord/ Nerve	_____	<input type="checkbox"/> Hernia (inguinal or hiatal)	_____
<input type="checkbox"/> Shoulder/ Arm/ Hip/ Leg	_____	<input type="checkbox"/> Other: _____	_____

Please list hospitalizations/ surgical procedures: _____

ARE YOU TAKING ANY MEDICATIONS PRESENTLY?

Please check all that apply. (I am **NOT** taking any medications currently)

<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Blood Pressure/ Stroke Prevention	<input type="checkbox"/> Endocrine-Hormone
<input type="checkbox"/> Anti-Inflammatory	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Birth Control
<input type="checkbox"/> Diabetic Medications	<input type="checkbox"/> Immunity Drugs	<input type="checkbox"/> Other: _____

CURRENT MEDICATIONS, NAME AND DOSE:

Name: _____	Dose: _____	Name: _____	Dose: _____
Name: _____	Dose: _____	Name: _____	Dose: _____
Name: _____	Dose: _____	Name: _____	Dose: _____
Name: _____	Dose: _____	Name: _____	Dose: _____

Are you allergic to any medications? _____

ARE YOU TAKING ANY VITAMINS/ MINERALS/ HERBS? YES NO

Name: _____	Dose: _____	Name: _____	Dose: _____
Name: _____	Dose: _____	Name: _____	Dose: _____

FAMILY HISTORY:

<u>DISEASE:</u>	<u>FAMILY MEMBER:</u>	<u>DISEASE:</u>	<u>FAMILY MEMBER:</u>
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Chronic Headaches	_____
<input type="checkbox"/> Seizures	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Rheumatoid Arthritis	_____	<input type="checkbox"/> Lupus	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Lung Problems	_____
<input type="checkbox"/> Osteoporosis	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Kidney Problems	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Liver Problems	_____	<input type="checkbox"/> Increased Cholesterol	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Other: _____	_____

Doctor Notes

DR. INITIALS

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Doctor Notes

REVIEW OF SYSTEMS:

NOTE: Below is a list of symptoms that may seem unrelated to the purpose of your visit. Knowledge of these conditions may influence the type of treatment/therapy you receive.

Please select the following: **P – PAST** **N - NOW**

CONSTITUTIONAL: No Symptoms

- P N Chills
- P N Daytime Drowsiness
- P N Fatigue
- P N Fever
- P N Night Sweats
- P N Weight Gain
- P N Weight Loss

Other: _____

EARS/ NOSE/ THROAT: No Symptoms

- P N Difficulty/ Loss of Hearing
- P N Ringing in the Ears
- P N Frequent Ear Aches
- P N Discharge from the Ear
- P N Attacks of Vertigo
- P N Sinus Trouble
- P N Nasal Blockage
- P N Frequent Sneezing
- P N Frequent Sore Throat
- P N Snoring
- P N Change in Voice Quality
- P N Sleep Apnea
- P N Difficulty in Swallowing
- P N Nose Bleeds

Other: _____

HEART & CIRCULATION: No Symptoms

- P N Heart Attack
- P N High Blood Pressure
- P N Heart Murmur
- P N Chest Discomfort
- P N Heart Failure or Fluid on Lungs
- P N Palpitations, Racing or Pounding
- P N Shortness of Breath w/Activity
- P N Stroke/ Mini Stroke or TIA
- P N Blood Clot in Artery or Vein
- P N "Black Out Spells"
- P N Aneurysm of any Blood Vessel
- P N Swelling of Legs
- P N Heart Surgery
- P N Heart Palpitations

Other: _____

EYES: No Symptoms

- P N Wear Glasses or Contacts
- P N Blindness
- P N Cataracts
- P N Glaucoma

Other: _____

RESPIRATORY: No Symptoms

- P N Asthma or Wheezing
- P N Bronchitis or Chest Cold
- P N Cough
- P N Coughing up Blood
- P N Shortness of Breath

Other: _____

STOMACH/ GASTROINTESTINAL: No Symptoms

- P N Ulcer
- P N Frequent Heartburn or Indigestion
- P N Hiatal Hernia & or Acid Reflux
- P N Poor Appetite
- P N Gall Bladder Attacks
- P N Frequent Diarrhea
- P N Chronic Constipation
- P N Bright Blood Bowels or Rectum
- P N Abnormal Stool
- P N Liver Disease or Jaundice

Other: _____

ENDOCRINE / METABOLISM: No Symptoms

- P N Thyroid Disorder
- P N Unusual Hair Loss or Growth
- P N Goiter
- P N Diabetes

Other: _____

ALLERGIES: No Symptoms

- P N Anaphylaxis
- P N Food Intolerance
- P N Itching
- P N Nasal Congestion
- P N Rash
- P N Sneezing

Other: _____

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Triad Pain Management Clinic
Patient Health History - Intake Form

Doctor Notes

NOTE: Below is a list of symptoms that may seem unrelated to the purpose of your visit. Knowledge of these conditions may influence the type of treatment/therapy you receive.

Please select the following: P – PAST N - NOW

KIDNEY/ URINARY: No Symptoms

- P N Kidney Disease or Failure
- P N History of Kidney Dialysis
- P N Kidney Stones or Infection
- P N Pain or Burning with Urination
- P N Trouble Starting Urinary Stream
- P N Dribbling or Incontinence
- P N Frequent Night Urination
- P N Bladder Infections During Past Year
- P N Blood in Urine During Past Year

Other: _____

PSYCHOLOGICAL: No Symptoms

- P N Anxiety
- P N Loss of Change in Appetite
- P N Behavioral Change
- P N Bi-Polar Disorder
- P N Confusion
- P N Convulsions
- P N Depression
- P N Insomnia
- P N Memory Loss
- P N Mood Change

Other: _____

NERVOUS SYSTEM: No Symptoms

- P N Headache
- P N Epilepsy or Seizures
- P N Date of Last Seizure _____
- P N Depression
- P N Other Nervous Disorder

Specify: _____

Other: _____

BLOOD: No Symptoms

- P N Bleeding or Bruising Tendency
- P N Previous Blood Transfusion
- P N History of Hepatitis

Other: _____

MEN ONLY: No Symptoms

- P N Testicular Swelling
- P N Prostate Problems
- P N Frequent Urination

Other: _____

MUSCULOSKELETAL: No Symptoms

- P N Neck Pain
- P N Joint Pain
- P N Osteoarthritis
- P N Back Pain
- P N Muscle Spasms
- P N Rheumatoid Arthritis
- P N Joint Injury
- P N Tennis Elbow
- P N Carpal Tunnel Syndrome
- P N Bursitis

Other: _____

WOMEN ONLY: No Symptoms

- P N Painful Periods
- P N Excessive Flow
- P N Irregular Cycles
- P N Vaginal Burning
- P N Hot Flash

Are you Pregnant? Yes No

Other: _____

PATIENT SIGNATURE

OFFICE USE ONLY:

Blood Pressure: _____ Height: _____ Weight: _____

Temperature: _____ Pulse: _____ Respiratory: _____

Notes: _____

DR. INITIALS