Pain Treatment Associates, LLC **Patient name_____**

Your Pain Management Specialists •1410 Doctors Drive •West Plains, MO 65775 Phone: (417) 256-BACK

HEALTH Q & A

1. **Family History:** **Living** **Deceased** **Medical Problems/Cause of Death**
   Father age _____ age _____ _____
   Mother age _____ age _____ _____

2. **Do you smoke?** □No □Yes. If yes are you interested in quitting? □No □Yes □Maybe. **If yes, how many cigarettes a day do you smoke? ___ Do you smoke every day?** □No □Yes. **How soon after you wake up do you smoke?** □5 minutes □6-30 minutes □31-60 minutes □after 60 minutes. **Do you chew?** □No □Yes, _____ **cans** per day; how long have you used tobacco products _____years _____months. **If you currently do not smoke, have smoked in the past?** □No □Yes; **if yes**, **how long has it been since you last smoked?_____**

3. **Have you EVER used marijuana?** □No □Yes, if yes how frequently? □Often □Occasionally □Rarely & date of last use? _____/_____/_____. *Honesty is the best policy*.

4. **Have you EVER used meth?** □No □Yes, if yes how frequently? □Often □Occasionally □Rarely & date of last use? _____/_____/_____. *Honesty is the best policy*.

5. **Have you EVER used any other illegal drugs?** □No □Yes, if yes how frequently? □Often □Occasionally □Rarely & date you last used them? _____/_____/_____. What types have you tried? _____ *Honesty is the best policy.*

6. **Do you drink alcohol?** _____ times daily _____ times weekly □Occasionally □Never

7. **Are you married?** □No □Yes □Divorced □Widowed

8. **Do you have children**? □No □Yes; How many _____

9. **What is your education level?** Highest grade completed? ____ □GED? □Some college □Graduated College

10. **Are you working?** □**No** □**Yes**, if yes □Full-time □Part-time, Occupation _____

11. **Are you receiving disability compensation?** □No □Yes **If no, do you plan to pursue disability compensation** □No □Yes

12. **Do you exercise** □No □Yes, If yes how often □Daily □3-5 days per week □1-2 days per week

13. **Have you ever worked around metal/welding?** □No □Yes, If yes, have you had metal in your eyes?__

14. **Have you traveled outside the United States?** □No □Yes **When**? _____ **Where**? _____

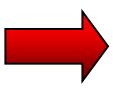
15. **My sleep is** □Poor □Fair □Good

16. **Please check any of the following that apply**

□ Frequent awakenings from sleep	□ Snoring	□ Difficulty in sleeping
□ Non-refreshing sleep	□ Confusion	□ Thrashing about during sleep
□ Restless legs	□ Restlessness during sleep	□ Impaired memory/intellectual function
□ Excessive daytime sleepiness	□ Morning headaches	□ Witnessed breathing cessation during sleep
□ Fall asleep while driving		

17. **Have you ever had a sleep study done?** □No □Yes, if yes…
    When? □Past 12 months □_____*Where?* □OMC Other_____
    Do you use a CPAP machine? □No □Yes

18. **How did you FIRST hear about us (before going to your doctor)?** □Radio _____
    □Horse Trader □Billboards □Newspaper _____ □Physician □Word of Mouth □Other _____



OVER PLEASE

Please mark any of the following that you are experiencing NOW …

Constitutional
□ recent change in overall health
□ recent weight gain? Lbs _____
□ recent weight loss? Lbs _____
□ loss of appetite
□ fever
□ weakness
□ fatigue
□ insomnia

Ophthalmology
□ blurred vision
□ itchy eyes
□ eye pain
□ glaucoma
□ use of eye glasses
□ use of contact lenses
□ dry eyes

HENT
□ diminished hearing
□ ear fullness
□ runny nose
□ nasal congestion
□ sinus congestion
□ seasonal allergies
□ environmental allergies
□ difficulty swallowing
□ dry mouth

Cardiovascular
□ dizziness
□ chest pain
□ arm swelling □ right □ left
□ leg swelling □ right □ left
□ cool extremities
□ irregular heart beat

Respiratory
□ smoking
□ chest pain
□ difficulty breathing
□ wheezing

Gastrointestinal
□ nausea
□ vomiting
□ heartburn
□ abdominal pain
□ diarrhea
□ constipation
□ blood in stool

Musculoskeletal
□ muscle cramps
□ joint pain
□ joint swelling
□ joint stiffness

Integumentary/Dermatology
□ rash, where? _____
□ itching, where? _____
□ irregular moles
□ irregular lumps

Neurology
□ arm weakness □ right □ left
□ leg weakness □ right □ left
□ numbness/tingling
□ seizures
□ memory loss
□ tremors
□ headaches
□ migraines

Psychiatric
□ depression
□ high stress level
□ hallucinations
□ history of physical abuse
□ history of sexual abuse
□ weird dreams
□ suicidal thoughts

Endocrine
□ excessive sweating
□ excessive thirst
□ excessive urination
□ cold intolerance
□ heat intolerance
□ diabetes, range of levels
_____ to _____

Hematology/Lymphatic
□ abnormal bruising
□ abnormal bleeding
□ varicose veins
□ enlarged lymph nodes

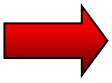
Female Genitourinary
□ sexually active
□ diminished sexual drive
□ menopause
□ irregular menstrual cycles
□ difficulty urinating

Male Genitourinary
□ sexually active
□ difficulty with erection
□ diminished sexual drive
□ impotence
□ difficulty urinating

Are you claustrophobic (during MRI)* **□No** **□Yes**

Previous Therapies **□ NO PREVIOUS THERAPY**

□ TENS □ with benefit □without benefit
□ Chiropractic treatment □ with benefit □without benefit ____ weeks of therapy
□ Physical therapy □ with benefit □without benefit ____ weeks of therapy
□ Ice/heat therapy □ with benefit □without benefit ____ weeks of therapy
□ Home exercises □ with benefit □without benefit ____ weeks of therapy
□ Other pain clinic treatment □ with benefit □without benefit (describe below)
□_____

PLEASE CONTINUE 

<u>CURRENT</u> Potential Work or Litigation Related Injury? □No □Yes; if yes, complete the following.
Is pain is due to a potential litigation related injury or event □No □Yes. Attorney: _____
Is the condition related to employment? □No □Yes.
Is the condition related to an accident? □No □Yes. State where incident occurred: _____.
Is the incident related to an automobile accident? □No □Yes.
Date/time incident occurred: _____. Date of onset of symptoms: _____.
Details of the
incident: _____
_____
Your responsibility: □Yes □No; incident was caused by another party.
Dates unable to work in current occupation: _____.
Dates of hospitalization(s) related to this incident: _____.

Allergies/Reaction □ No ALLERGIES

_____

_____

_____

_____

Surgeries/date/location/physician □ No SURGERIES

_____

_____

_____

_____

_____

Hospitalizations (other than surgeries)/date □ No HOSPITALIZATIONS

_____

_____

_____

Medical History (diabetes, hypertension, etc) □ No MEDICAL HISTORY

_____

_____

_____

_____

_____

I have filled out this questionnaire *completely* and my answers are *truthful* and accurate. If I have any questions about this form, I know to ask the nurse for clarification before signing this form. I understand that filling out this form inaccurately or untruthfully may result in complications in my medical treatment.

Patient Signature:_____ Date:_____

Patient Printed Name:_____ Date of birth:_____