PIEDMONT PHYSICAL MEDICINE & REHABILITATION, P.A.

Specializing in:
- Complex, Chronic Pain
- Non-Surgical Specialty Care
- Vascular Medicine

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Robert G. Schwartz, M.D. **Matthew Terzella, MD**

NAME: _____ **AGE:** _____

HISTORY OF PRESENT ILLNESS:

1. WHERE DO YOU HURT? _____

_____

2. HOW WOULD YOU DESCRIBE THE PAIN (SHARP, SHOOTING, DULL, ACHY, CRAMPING, ETC.?) _____

_____

3. WHAT DATE DID IT START? (COMPLETE EVEN IF PAIN IS NOT YOUR PRIMARY COMPLAINT)

_____

4. WHAT CAUSED IT TO START (CAR WRECK, WORK INJURY, SPORTS INJURY, DON'T KNOW, ETC.?) _____

_____

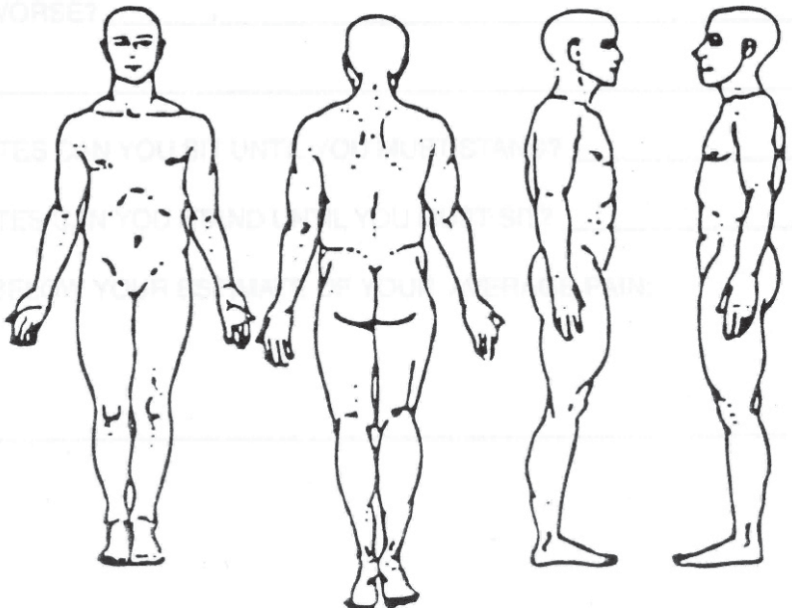
5. IF YOU WERE IN A CAR WRECK: (A) WERE YOU THE DRIVER OR PASSENGER? _____

(B) DID YOU HAVE ON A SEATBELT? _____ (C) HOW FAST WERE BOTH CARS TRAVELING? _____

(D) HOW MUCH VISIBLE DAMAGE WAS THERE TO YOUR CAR? _____

(E) WHAT DID IT COST TO FIX THE CAR? _____

6. PLEASE MARK ON THE DRAWINGS BELOW THE AREAS WHERE YOU FEEL PAIN.



B. 1. DO YOU HAVE ANY WEAKNESS IN PARTS OF YOUR BODY?_____ WHERE?_____

_____

2. DO YOU HAVE ANY NUMBNESS (pins & needles or cold feelings) IN PARTS OF YOUR BODY? _____
WHERE? _____

3. PLEASE CHECK WHICH OF THESE SYMPTOMS, IF ANY, YOU HAVE NOTICED ASSOCIATED WITH YOUR PAIN:

_____	EARS RINGING	_____	HOT/COLD SENSATIONS
_____	BLURRED VISION	_____	OVERLY SENSITIVE SKIN
_____	TROUBLE SWALLOWING	_____	CONGESTION
_____	CHRONIC FATIGUE	_____	TROUBLE SLEEPING
_____	TIGHTNESS	_____	LIMB SWELLING
_____	BALANCE PROBLEMS	_____	OTHER _____

4. DO YOU HAVE ANY PROBLEM WITH LOSS OF BOWEL OR BLADDER CONTROL? _____

_____

5. HAVE YOU EVER HAD A PAIN IN THE PAST IN THE SAME PART OF YOUR BODY?_____

_____

6. DOES YOUR PAIN INCREASE IF YOU COUGH OR SNEEZE?_____

7. DOES THE WEATHER OR TEMPERATURE AFFECT YOUR PAIN?_____

8. DO YOU ALWAYS HAVE COLD HANDS OR FEET?_____

C. 1. WHAT MAKES THE PAIN BETTER? _____

_____

2. WHAT MAKES IT WORSE? _____

_____

3. HOW MANY MINUTES CAN YOU SIT UNTIL YOU MUST STAND? _____

4. HOW MANY MINUTES CAN YOU STAND UNTIL YOU MUST SIT? _____

D. MARK ON THE LINE BELOW YOUR ESTIMATE OF YOUR AVERAGE PAIN:

0 _____ **10**

E. 1. PLEASE NAME ANY DOCTORS YOU HAVE SEEN FOR YOUR PAIN SO FAR. _____

_____

2. WHAT TEST HAVE THEY DONE (BLOOD TEST, X-RAYS, CT SCANS, BONESCAN, MYELOGRAM, EMG, MRI)?

_____

3. WHERE WERE THESE TEST DONE? _____

_____

4. WERE ANY OF THEM ABNORMAL? _____ IN WHAT WAY? _____

_____

5. HAVE YOU EVER HAD FREQUENT OR SEVERE INFECTIONS? _____

6. DO YOU HAVE A PERSONAL OR FAMILY HISTORY OF ANY BLEEDING, BRUISING OR CLOTTING DISORDERS?

_____

7. HAVE YOU HAD ANY UNUSUAL ENVIRONMENTAL EXPOSURES? _____

8. HAVE YOU EVER TAKEN AN MMPI? _____

F. 1. WHAT MEDICINE HAVE YOU TAKEN FOR THE PAIN IN THE PAST? _____

_____

2. WHAT PAIN MEDICINES ARE YOU TAKING NOW?

NAME	DOSAGE	FREQUENCY	DATE STARTED

3. HAVE YOU EVER HAD ANY SURGERY FOR YOUR PAIN? _____ WHAT KIND? _____

_____

4. WHAT OTHER KIND OF TREATMENT (PHYSICAL THERAPY, CHIROPRACTIC, HYPNOSIS, INJECTIONS, ETC.) HAVE YOU TRIED FOR YOUR PAIN? _____

_____

G. PAST MEDICAL HISTORY:

1. DO YOU HAVE DIABETES, HIGH BLOOD PRESSURE, CARDIOVASCULAR DISEASE, STOMACH ULCERS OR OTHER MEDICAL PROBLEMS? _____

2. ARE YOU TAKING ANY MEDICINES? _____ WHICH ONES? _____

_____

3. WHAT SUPPLEMENTS IF ANY, DO YOU TAKE? _____

4. WHO IS YOU PRIMARY CARE PROVIDER? _____

5. ARE YOU ALLERGIC TO ANY MEDICINES? YES / NO WHICH ONES AND WHAT HAPPENS? _____

_____

6. HAVE YOU EVER HAD SURGERY OF ANY KIND? _____ FOR WHAT? _____

_____

7. HAVE YOU EVER HAD A FRACTURED BONE? _____ WHERE? _____

_____

8. ARE YOU RIGHT OR LEFT HANDED? _____

H. REVIEW OF SYSTEMS:

1. CONSTITUTIONAL: ANY RECENT OR UNUSUAL WEIGHT LOSS? _____

2. HEENT: ANY DIFFICULTY WITH VISION OR HEARING? _____

3. CARDIOVASCULAR: ANY CHEST PAIN OR PALPITATIONS? _____

4. RESPIRATORY: ANY CURRENT OR RECENT INFECTION? _____

5. HEMATOLOGIC: IS THERE ANY UNUSUAL BLEEDING OR ANEMIA? _____

6. GI: ANY UNUSUAL CONSTIPATION OR DIARRHEA? _____

7. GU: ANY FREQUENCY OR URGENCY OR URINATION? _____

8. SKIN: ANY OPEN SORES? _____

9. NEUROLOGICAL: ANY DOUBLE VISION OR TROUBLE SWALLOWING? _____

10. PSYCHIATRIC: ANY CONFUSION ON THE DATE, YOUR NAME OR WHERE YOU ARE? _____

I. FUNCTIONAL HISTORY:

1. CAN YOU FEED, BATHE AND DRESS YOURSELF? _____

2. DO YOU NEED ADAPTIVE AIDS (BRACES, ETC.) TO WALK? _____

3. RATE YOUR FUNCTIONAL INDEPENDENCE. 0 _____ 5 _____ 10

Totally Dependent | Wheelchair Independent | Complete Indepedence

J. FAMILY HISTORY (IF ANY LINE IS AFFIRMATIVE PLEASE INDICATE WHICH FAMILY MEMBER):

1. HAVE ANY OF YOUR BLOOD RELATIVES HAD ARTHRITIS? _____

2. HAVE ANY OF YOUR BLOOD RELATIVES HAD CANCER? _____

3. HAVE ANY OF YOUR BLOOD RELATIVES HAD HEART OR VASCULAR DISEASE? _____

K. SOCIAL HISTORY

1. ARE YOU MARRIED? _____
2. HOW MANY CHILDREN DO YOU HAVE? _____
3. WHAT ARE THEIR AGES? _____
4. DO YOU DRINK ALCOHOL? _____ HOW MUCH? _____
5. DO YOU SMOKE CIGARETTES? _____ HOW MANY? _____
6. ARE YOU PRESENTLY WORKING? _____ FOR WHOM? _____
7. IF YOU WERE INJURED AT WORK, WHERE DID YOU WORK AT THE TIME? _____
8. HOW LONG HAVE YOU BEEN EMPLOYED BY THE PLACE OF EMPLOYMENT WHERE YOU WERE INJURED?

   _____
9. WHAT IS YOUR JOB? _____
10. WHEN DID YOU LAST WORK? _____
11. WHAT LEVEL OF EDUCATION HAVE YOU COMPLETED? _____
12. WHAT IS THE OCCUPATION OF YOUR SPOUSE? _____
13. ARE YOU INVOLVED IN A LAW SUIT BECAUSE OF YOUR PAIN? _____
14. WHAT IS YOUR ATTORNEY'S NAME AND ADDRESS? _____

    _____

1. DO YOU REQUIRE A FEMALE STAFF MEMBER AS A CHAPERONE WITH YOU IN THE EXAM ROOM DURING EACH VISIT? ☐NO ☐YES
2. ON OCCASION THERE MAY BE A VISITING PHYSICIAN PRESENT WITH THE DOCTOR DURING VISITS. DO YOU HAVE ANY OBJECTION TO THIS? ☐ NO ☐ YES

_____ _____

PATIENT'S SIGNATURE
(GUARDIAN SIGNATURE IF PATIENT IS A MINOR)

DATE

_____

RELATIONSHIP IF OTHER THAN PATIENT