PROVIDENCE
St. Mary
Neuroscience Institute

Patient label

PCP: _____ Who Referred? _____

Why are you seeing the doctor today? _____

_____

Please list major complaint(s) and describe their onset (i.e., lower back pain began in May 2012 after lifting):

_____

Are you having any? □ Numbness Where? _____
□ Weakness Where? _____
□ Loss of bowel or bladder control

What makes your symptoms better (please circle all that apply): Nothing, rest, changing position, standing, sitting, walking, running, kneeling, bending, twisting.

What worsens your symptoms (please circle all that apply): Nothing, rest, changing position, standing, sitting, walking, running, kneeling, bending, twisting.

Is this visit related to an injury? □ Yes □ No On the job? □ Yes □ No

If so, date of injury: _____ Date of last employment: _____

Do you have any open worker's compensation claims of any kind? □ Yes □ No
Do you have a lawsuit pending? □ Yes □ No
Please circle the description which applies to your intensity of pain: Stable, unchanged, gradually worsening, rapidly worsening, gradually improving, rapidly improving, completely resolved.

How long has the problem been present? _____ Day(s), _____ Week(s), _____ Month(s), _____ Year(s)

What started the pain/problem? _____

Quality of the pain (mark up to four): □ Sharp □ Shooting □ Crushing □ Tight Band
□ Numbing □ Pulsating □ Aching
□ Tingling □ Dull □ Throbbing

How severe is the pain at the location described above? □ No Pain □ Mild □Moderate □ Severe

Is the pain (check all that apply)? □ Rare □ Infrequent □ Occasional □ Intermittent
□ Daily □ Continuous □ Weekly □ Monthly

What treatments have you tried for this problem?

□ Physical Therapy □ TENS units □ Narcotic Medications □ Muscle Relaxers
□ Massage □ Traction □ Anti-inflammatories □ Orthotics
□ Chiropractor □ Surgery □ Steroid injections □ Braces
□ Other: _____

Previous physicians seen for this problem?

Physician	Specialty	City	Treatment

Have you ever had general anesthesia? □ Yes □ No

If yes, have you had any problems related to this? □ Yes □ No

Explain any problems with general anesthesia: _____

Are you currently smoking? □ Yes □ No If yes, how many pack/day? _____ And for how many years? _____

Have you previously quit smoking? If so, when did you quit? _____ How many years did you smoke? _____

How many packs a day did you previously smoke? _____ Other forms of tobacco used? _____

Alcohol use: □ Never □ Rare □ Social □ Frequently (more than twice a week)
□ Alcoholic □ Recovering alcoholic

Illegal drug use: □ Never □ In the past □ Currently □ Types of drugs? _____

Patient label

PAIN DIAGRAM

On the diagram below, please indicate where you are experiencing pain or other symptoms.

Use the following to describe your symptoms:

A = Ache

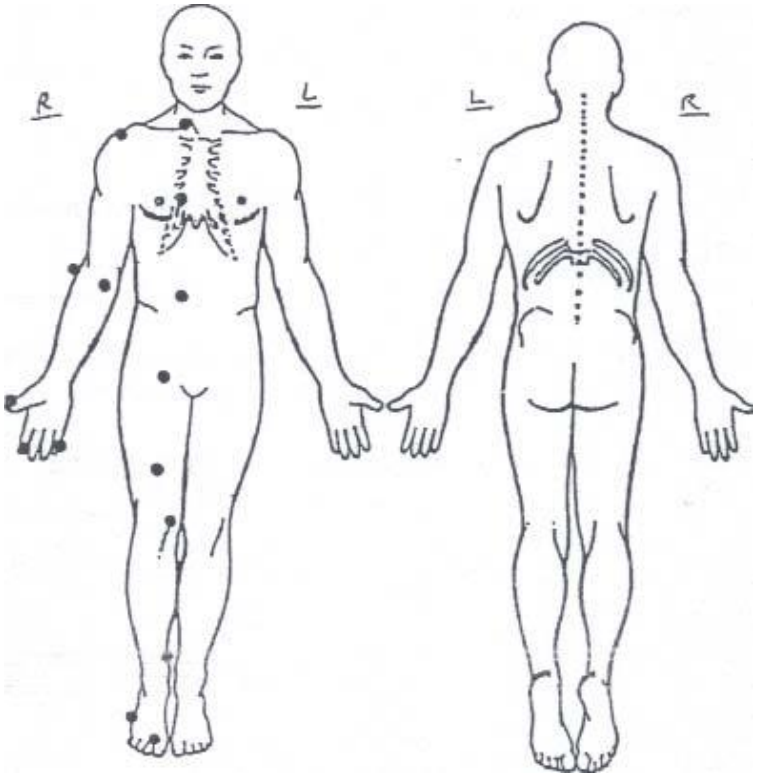
B = Burning

N = Numbness

P = Pins & Needles

S = Stabbing

O = Other



Please rate your usual level of pain on the following scale (circle one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Patient's signature: _____ Date: _____