FK RH NC OM GW SM EH
Form 6 - Revised: 06/15/2010

Interventional Initial History

Delaware Back Pain & Sports Rehabilitation Centers

Name: _____ **Date:** ____/____/_____

DOB: ____/____/_____ Please provide the following medical information to the best of your ability.

CHIEF COMPLAINT: What is the main reason for your visit? _____

_____

1. Date of your accident/injury? _____ **(**If neither one skip to "C" below)

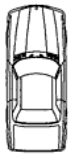
A. Motor Vehicle Accident: Yes ❑ No ❑

Driver ❑ Passenger ❑

Seat Belt ❑ Air Bag Deployed ❑

Indicate site of impact:

"P" = Primary "S" = Secondary



Did you hit your head? Yes ❑ No ❑

Any loss of consciousness? Yes ❑ No ❑

Memory problems? Yes ❑ No ❑

B. Work Related Injury:

Yes ❑ No ❑

Has this injury been accepted as a Worker's Compensation claim?

Yes ❑ No ❑

C. Describe your accident/injury or history of problem in detail. _____

_____

_____

_____

_____

_____

_____

_____

_____

2. Have your symptoms gotten…. Worse ❑ Better ❑ Same ❑ (check only one)

3. Your present pain is…. Constant ❑ Intermittent ❑ Worse in the… A.M. ❑ P.M. ❑

4. What activities increase your pain? Sitting ❑ Standing ❑ Walking ❑ Lifting ❑ Housework ❑
Coughing/Sneezing ❑ Lying flat on back ❑ Lying flat on stomach ❑

5. What activities decrease your pain?
Sitting ❑ Standing ❑ Walking ❑ Lying flat on back ❑ Lying flat on side with knees bent ❑

6. Are you: Right-Handed ❑ Left-Handed ❑

7. Do you have any <u>pain</u> going down your arm or leg… ❑ No ❑Yes (if "yes" circle the area involved)
Right Arm Left Arm Right Leg Left Leg

Do you have any <u>numbness/tingling</u> down your arm or leg… ❑ No ❑Yes (if "yes" circle the area involved)
Right Arm Left Arm Right Leg Left Leg

Do you have any <u>weakness</u> of your arm or leg… ❑ No ❑Yes (if "yes" circle the area involved)
Right Arm Left Arm Right Leg Left Leg

8. Do you have difficulty sleeping because of pain? Yes ❑ No ❑

9. Have any other physicians evaluated you for this problem? Yes ❑ No ❑

If yes, who/when? _____

10. Have any tests (x-rays, CT scan, MRI) been done to evaluate this problem? Yes ❑ No ❑

If yes, please describe and give the facility name: _____

Reviewed By Initials _____

Initial History (cont'd) **Name: _____Date _____/_____/_____**

11. What treatments have you received? Please describe (ex: PT, Chiro, Surgery)

_____ Made Better ❑ Worse ❑ No Change ❑
_____ Made Better ❑ Worse ❑ No Change ❑
_____ Made Better ❑ Worse ❑ No Change ❑

12. Have you had any previous accident, injury or problems with your neck, back, shoulders, or knees?

Yes ❑ No ❑ If yes, please describe where and when: _____

_____

_____

13. Pain Medications that you are taking now:

List all your pain medicines including any that are over-the-counter such as Tylenol, Aleve, etc.

Name	Does it help?	Side effects?
	Yes ❑ No ❑	
	Yes ❑ No ❑	
	Yes ❑ No ❑	

14. Pain Medications that you have taken in the past:

Name	Did it help?	Side effects?
	Yes ❑ No ❑	
	Yes ❑ No ❑	
	Yes ❑ No ❑	

15. All other regular medicines if any: (ex: for blood pressure, diabetes, ulcers, blood thinners)

(Please include any over-the-counter drugs, eye drops, vitamins, etc.)

Name	For how long?	Side effects?

16. Drug allergies:

❑ Aspirin	❑ Sulfa drugs	❑ Novocain/Lidocaine	❑ Iodine Dye	❑ Penicillin	❑ Shellfish	❑ Latex
❑ Other: (write medicine name and reaction)						

17. Past Medical History - Please check the "Yes" or "No" box if you have any of the following illnesses; for "Yes" answers, please explain.

Diabetes	Yes ❑	No ❑_____	Thyroid problems	Yes ❑	No ❑_____
Hypertension (high blood pressure)	Yes ❑	No ❑_____	Allergy problems/Therapy	Yes ❑	No ❑_____
Heart Disease	Yes ❑	No ❑_____	Kidney/Bladder/Prostate problems	Yes ❑	No ❑_____
High Cholesterol	Yes ❑	No ❑_____	Neurological problems	Yes ❑	No ❑_____
Respiratory problems	Yes ❑	No ❑_____	Addiction or Substance Abuse	Yes ❑	No ❑_____
Stomach/Intestinal problems	Yes ❑	No ❑_____	Mental Health/Psychiatric	Yes ❑	No ❑_____
Bleeding Disorder	Yes ❑	No ❑_____	Other medical diagnosis	Yes ❑	No ❑_____

18. Past Surgical History: (Please list all surgeries)

Type of Surgery	When & Name of Surgeon

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Reviewed By (Initials) _____

Initial History(cont'd) **Name: _____ Date _____/_____/_____**

19. Review of systems:

a. Please check the "Yes" or "No" box if you have any of the following symptoms.
b. Check the "Current" box if this symptom relates to the reason for your visit today.

		Yes	No	Current		Yes	No	Current
GENERAL	Chills	❑	❑	❑	Weight Loss or Gain	❑	❑	❑
	Fatigue	❑	❑	❑	Daytime Sleepiness	❑	❑	❑
ALLERGY	Environmental	❑	❑	❑	Sneezing fits	❑	❑	❑
NEURO	Passing out	❑	❑	❑	Seizures	❑	❑	❑
	Weakness	❑	❑	❑	Numbness/tingling	❑	❑	❑
	Memory loss	❑	❑	❑	Abnormal ache	❑	❑	❑
EYES	Eye pain/pressure	❑	❑	❑	Vision Changes	❑	❑	❑
ENT	Ringing in ears	❑	❑	❑	Dizziness	❑	❑	❑
	Hearing loss	❑	❑	❑	Sinus pain	❑	❑	❑
	Snoring	❑	❑	❑	Sore throat	❑	❑	❑
RESPIRATORY	Cough	❑	❑	❑	Coughing Blood	❑	❑	❑
	Wheezing	❑	❑	❑	Shortness of breath	❑	❑	❑
CARDIAC	Chest Pain	❑	❑	❑	Palpitations	❑	❑	❑
	Wake short of breath	❑	❑	❑	Ankle Swelling	❑	❑	❑
GASTRO - INTESTINAL	Difficulty Swallowing	❑	❑	❑	Heartburn	❑	❑	❑
	Abdominal Pain	❑	❑	❑	Nausea/Vomiting	❑	❑	❑
	Bowel Irregularity	❑	❑	❑	Rectal Bleeding	❑	❑	❑
GENITOURINARY	Frequent Urinating	❑	❑	❑	Painful Urination	❑	❑	❑
	Blood in urine	❑	❑	❑	Prostate Problems	❑	❑	❑
	Loss of bladder control	❑	❑	❑	Is there a chance you are pregnant?	❑	❑	❑
HEME/LYMPH	Swollen glands	❑	❑	❑	Sweating at night	❑	❑	❑
	Bleeding problems	❑	❑	❑	Easy Bruising	❑	❑	❑
ENDOCRINE	Feel warmer than others	❑	❑	❑	Feel cooler than others	❑	❑	❑
MUSCULOSKEL	Joint pain/stiffness	❑	❑	❑	Cramps	❑	❑	❑
	Muscle ache	❑	❑	❑	Weakness	❑	❑	❑
	Loss of mobility	❑	❑	❑				
DERMATOLOGIC	Rash	❑	❑	❑	Hives	❑	❑	❑
	Itching	❑	❑	❑	Skin or Hair changes	❑	❑	❑
MENTAL HEALTH	Nervousness	❑	❑	❑	Tension	❑	❑	❑
	Mood changes	❑	❑	❑	Depression	❑	❑	❑
	Anxiety/panic	❑	❑	❑				

20. Family History: Please check the "Yes" or "No" box if any relatives have/had any of the following illnesses.
If yes, please indicate which relative(s) have/had the problem.

	Yes	No	
Back problems	❑	❑	_____
Rheumatoid Arthritis	❑	❑	_____
Heart problems/murmurs	❑	❑	_____
Diabetes	❑	❑	_____
Cancer	❑	❑	_____
Bleeding Disorder	❑	❑	_____
Anesthesia problems	❑	❑	_____

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Reviewed By (Initials) _____

Initial History(cont'd) **Name: _____Date ____/____/_____**

21. Are you currently: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

22. Where do you live? ❑-Apartment ❑2-Story House ❑-Ranch-Style House

23. How many children do you have? _____ Ages _____ How many live with you _____

24. Do you smoke cigarettes? ❑ Yes ❑ No Packs per day: _____

25. Do you drink alcoholic beverages? Yes ❑ No ❑ How much each day?_____

26. Do you take or have you ever used any street drugs(ex-marijuana, cocaine, etc.)? Yes ❑ No ❑

27. Are you working? ❑ Yes ❑ No ❑ Full-Time ❑ Part-Time

When did you last work? Date: _____ **Is there light duty available at work?** ❑ Yes ❑ No

28. Occupation and job duties: (ex: sitting at a computer, lifting, bending, twisting, etc.)

_____

29. If you are not working now, do you see yourself…. (check all that apply)

❑ returning to the same job ❑ modifying your work
❑ changing jobs – same employer ❑ changing jobs – different employer
❑ retraining or returning to school ❑ applying for early retirement or long-term disability benefits

30. Do you enjoy your work? ❑ Yes ❑ No

31. Do you like your co-workers? ❑ Yes ❑ No

32. What hobbies or activities (work, sports, and hobbies) do you hope to return? _____

_____

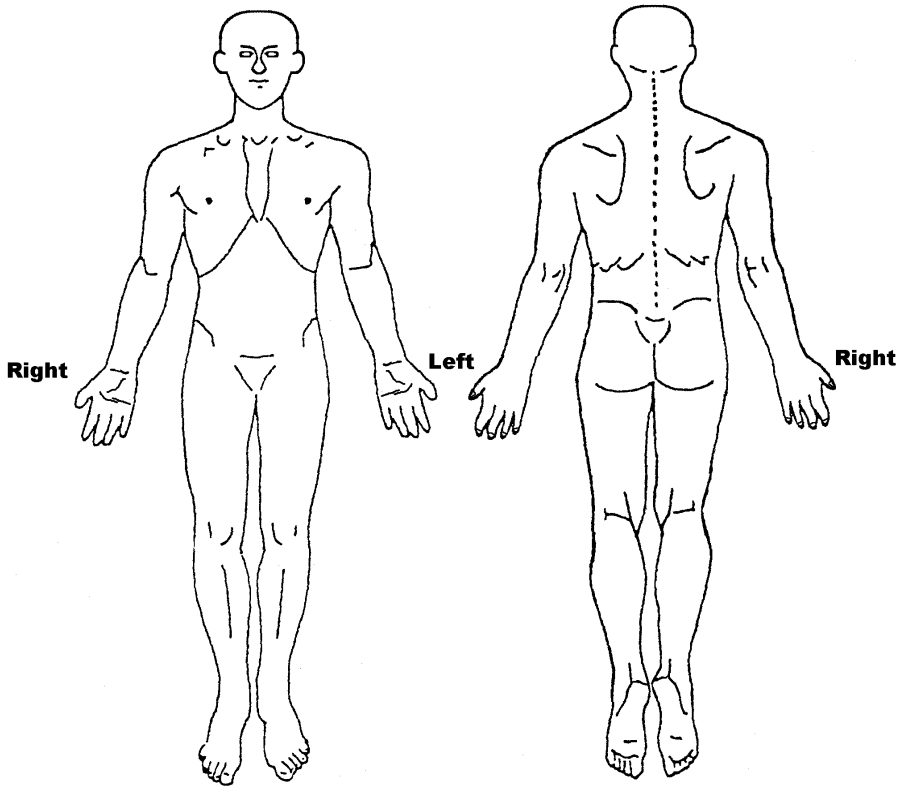
PAIN DRAWING

INSTRUCTIONS:

Mark these drawings according to where you hurt (if the back of your neck hurts, mark the drawing on the back of the neck, etc.). If you feel any of the following symptoms, please indicate which sensations you feel by placing the marks shown below.

KEY

XXX for Burning	/// for Stabbing	+++ Aching	**OOO** Pins & Needles	=== Numbness



PAIN LEVEL: (Circle one)

0 1 2 3 4 5 6 7 8 9 10

(no pain) (tolerate pain without medication) (requires medication) (go to ER) (severe pain) (admit to hospital for pain control)

Delaware Back Pain & Sports Rehabilitation Centers

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200 Banning Street, Suite-350, Dover, DE 19904 ~ 302-730-8848
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Reviewed by (initials) _____

See attached dictation ❑