Joseph Schifini, M.D. **DATE** ____/____/____

PLEASE FILL OUT THIS FORM *COMPLETELY* SO WE CAN HELP YOU WITH YOUR PAINFUL CONDITION.

NAME:_____ **AGE**:_____ **SEX**: M / F **HEIGHT** ___'___" **WEIGHT**_____**lbs**
OCCUPATION:_____ **DATE LAST WORKED**____/____/____

CC: **WHY** WERE YOU REFERRED TO OUR CLINIC?_____

HPI: PLEASE **DESCRIBE YOUR PAIN** BY ***SHADING*** IN THE AFFECTED AREAS AND ***PLACING AN 'X'*** ON THE AREA THAT HURTS THE MOST. ***CIRCLE*** ALL APPLICABLE DESCRIPTIVE WORDS.

CONSTANT **T**EMPORARY

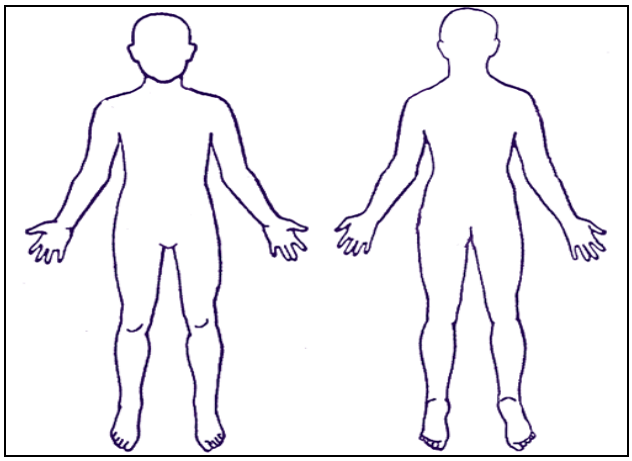
DAILY **O**CCASIONAL

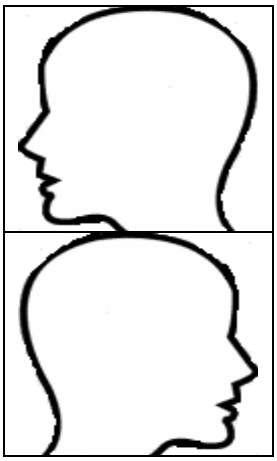
ACHING **S**HOOTING

BURNING **S**TABBING

NUMBING **T**INGLING

PINS/**N**EEDLES





PLEASE ATTEMPT TO QUANTIFY YOUR PAIN USING PERCENTAGES. YOUR TOTAL PAIN SHOULD ADD UP TO 100%. (*EXAMPLE:* 20% LOW BACK PAIN AND 80% RIGHT LEG PAIN = 100%.)

HEAD_____% **N**ECK_____% **R**IGHT **A**RM_____% **L**EFT **A**RM_____%

CHEST_____% **A**BDOMEN_____% **U**PPER **B**ACK_____% **M**ID **B**ACK_____%

LOWER **B**ACK_____% **H**IPS/**B**UTTOCKS_____% **R**IGHT **L**EG_____% **L**EFT **L**EG_____%

CIRCLE THE ACTIVITIES WHICH TEND TO ***INCREASE*** YOUR PAIN:

WALKING **L**IFTING **B**ENDING **T**WISTING **S**TANDING **S**ITTING

FILL IN ACTIVITIES WHICH ***DECREASE*** YOUR PAIN:_____

DOES THIS PAIN AFFECT YOUR **SLEEP**? **Y**ES / **N**O

CURRENT ***PAIN*** MEDICATIONS:_____PRESCRIBED BY **DR.**_____

MARK YOUR *AVERAGE* PAIN SCORE:
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

MARK YOUR *WORST* PAIN SCORE:
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
NOTE: (*ZERO* EQUALS *NO PAIN* AND *TEN* EQUALS YOUR *WORST* IMAGINABLE PAIN)

***WHEN* DID THIS PAIN BEGIN?**_____ (**S**PONTANEOUS/ **I**NJURY/ **A**CCIDENT/ **S**URGERY/ **O**THER)
PLEASE ***DESCRIBE*** **HOW** IT BEGAN:

_____
_____
_____
_____

HAVE YOU EVER HAD ANY ACCIDENTS OR INJURIES AFFECTING THESE SAME AREAS BEFORE? YES / NO
IF **YES**, WHEN?_____

TREATMENT: WHICH TYPES OF TREATMENT HAVE YOU HAD IN THE PAST TO TREAT YOUR CURRENT PAIN. PLEASE ***CIRCLE*** ALL THAT APPLY.

PAIN **C**LINIC **P**HYSICAL **T**HERAPY **M**ASSAGE **C**HIROPRACTIC **I**NJECTIONS **S**URGERY

ACUPUNCTURE **M**AGNETS **H**ERBS **O**THER:_____

PLEASE *LIST* ALL TREATMENT BELOW:

HEALTH CARE PROFESSIONAL	**APPROXIMATE DATES**	**DIAGNOSIS**	**TREATMENT/ MEDICATIONS**

DIAGNOSTIC EXAMINATIONS: PLEASE ***CIRCLE*** ALL THAT APPLY

XRAY **CT**-SCAN **M**RI **M**YELOGRAM **E**MG/**N**CV **O**THER_____

PAST/CURRENT MEDICAL HISTORY: PLEASE ***CIRCLE*** ALL THAT APPLY:

ARTHRITIS **A**STHMA **B**LEEDING **P**ROBLEMS **C**ANCER **C**IRRHOSIS **C**OLITIS **D**IABETES **E**MPHYSEMA
HEART TROUBLE **H**EPATITIS / **J**AUNDICE **H**IGH **B**LOOD **P**RESSURE **H**IV / **A**IDS **K**IDNEY **D**ISEASE
MURMUR **S**EIZURE **S**TROKE **T**HYROID **T**ROUBLE **U**RINATING **U**LCER **V**ASCULAR **D**ISEASE

ARE YOU TAKING ANY **BLOOD THINNERS** SUCH AS **COUMADIN, WARFARIN, PLAVIX, OR TICLID? YES / NO**
LIST ALL CURRENT **MEDICATIONS:**_____

ALLERGIES TO **MEDICATIONS**:_____

PAST SURGICAL HISTORY: (PLEASE ***LIST*** **ALL OPERATIONS** YOU HAVE HAD)_____
_____

SH: SINGLE____ **M**ARRIED____ **D**IVORCED____ **S**EPARATED____ **W**IDOWED____ **#** OF **C**HILDREN____

PACKS OF **CIGARETTES** SMOKED/DAY_____ # OF **ALCOHOLIC** BEVERAGES/DAY_____

HISTORY OF **SUBSTANCE ABUSE YES / NO** IF **YES**, WHAT TYPE?_____

FH: ***LIST*** **ANY ILLNESSES** WHICH RUN IN YOUR **FAMILY:** _____

ROS: PLEASE ***CIRCLE*** ALL **SYMPTOMS** YOU MAY CURRENTLY HAVE: **C**HANGE IN **V**ISION **C**HEST **P**AIN
COUGH **D**IARRHEA / **C**ONSTIPATION **D**IZZINESS **E**ASY **B**LEEDING **F**AINTING **F**EVER **I**TCHING
SHORTNESS OF **B**REATH **S**TOMACH **P**ROBLEMS **U**RINARY **P**ROBLEMS **W**EIGHT **L**OSS / **W**EIGHT **G**AIN

WHO IS YOUR CURRENT **PRIMARY CARE PHYSICIAN / PROVIDER:**_____