



# Allogoy Associates, P.C

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## Medical Evaluation of the Patient

PATIENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_ REFERRING PHYSICIAN: \_\_\_\_\_

### Pain History

1. WHERE & HOW LONG HAVE YOU HAD YOUR PAIN?

\_\_\_\_\_

2. WAS THERE AN ACCIDENT, INJURY, SURGERY OR ILLNESS RELATED TO YOUR PAIN? \_\_\_\_\_ NO \_\_\_\_\_ YES

DESCRIBE \_\_\_\_\_

\_\_\_\_\_

3. CIRCLE THE LETTER THAT BEST DESCRIBES THE TIMING OF YOUR PAIN.

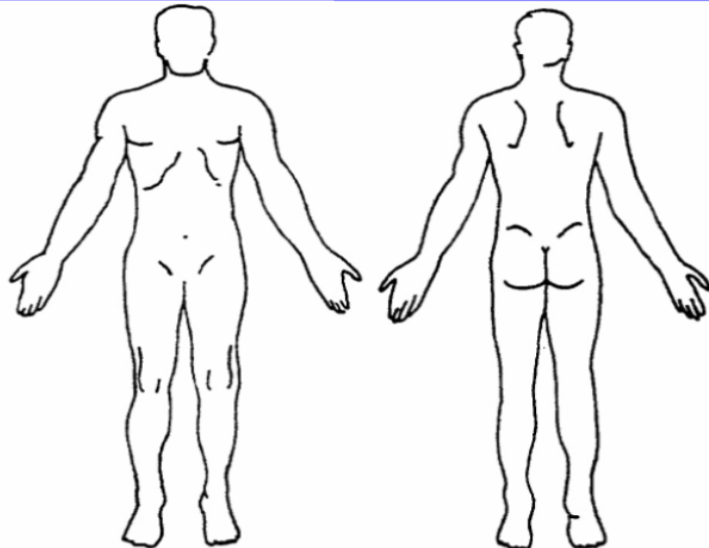
- A. CONSTANT, ALWAYS SAME INTENSITY
- B. CONSTANT, INTENSITY VARIES
- C. INTERMITTENT WITH SHORT PERIODS WITHOUT PAIN
- D. OCCASIONALLY, PRESENT FOR BRIEF PERIODS

4. DESCRIBE YOUR PAIN:

\_\_\_\_ SHARP \_\_\_\_ DULL \_\_\_\_ BURNING  
\_\_\_\_ THROBBING \_\_\_\_ PINCHING \_\_\_\_ SHOOTING  
\_\_\_\_ PRESSING \_\_\_\_ SQUEEZING \_\_\_\_ OTHER:(SPECIFY) \_\_\_\_\_

5. SHADE IN THE AREAS WHERE YOU HAVE PAIN:

Please mark the location(s) of your pain on the diagrams with an "x". If whole areas are painful, please shade in the painful area.



**6. DOES YOUR PAIN RADIATE OR TRAVEL?**  NO  YES  
(WHERE) \_\_\_\_\_

**7. DO YOU HAVE:**

NUMBNESS     TINGLING     WEAKNESS     COLDNESS  
 MUSCLE SPASM AND TIGHTNESS     BOWEL OR BLADDER PROBLEMS  
 INCREASED SWEATING     SKIN DISCOLORATION  
 HYPERSENSITIVITY TO PAIN

**8. CIRCLE THE NUMBER THAT CORRESPONDS TO THE SEVERITY OF YOUR PAIN.**

TODAY I HAVE *NO PAIN (0 1 2 3 4 5 6 7 8 9 10) MOST SEVERE*  
THE WORST PAIN YOU EVER HAVE (FROM 0-10) IS: \_\_\_\_\_  
THE LEAST PAIN YOU EVER HAVE (FROM 0-10) IS: \_\_\_\_\_

**9. CHECK ITEMS WHICH INCREASE YOUR PAIN:**

SITTING     STRESS     DRIVING     STANDING     WALKING  
 COUGHING     SNEEZING     WEATHER     ALCOHOL  
 PHYSICAL ACTIVITY     LAYING DOWN     TIME OF DAY (\_\_\_\_\_)  
 OTHER \_\_\_\_\_

**10. CHECK ITEMS WHICH DECREASE YOUR PAIN:**

REST     SITTING     WALKING     STANDING  
 MEDICATIONS     LAYING DOWN     PHYSICAL ACTIVITY  
 HEATING PADS     TIME OF DAY (\_\_\_\_\_)  
 OTHER \_\_\_\_\_

**11. SINCE YOUR PAIN BEGAN, HAS IT:**

A. INCREASED    B. DECREASED    C. STAYED THE SAME

**12. DOES PAIN FREQUENTLY AWAKEN YOU FROM SLEEP?**  NO  YES

**13. HAS PAIN INTERFERED WITH YOUR DESIRE/ABILITY FOR SOCIAL LIFE?**

NO INTERFERENCE     MINIMAL CHANGE     CONSIDERABLE CHANGE  
 STOPPED DESIRE

**14. RATE YOUR ABILITY TO COPE WITH PAIN:**

\_\_\_TOTALLY UNABLE \_\_\_MODERATELY UNABLE \_\_\_MILDLY UNABLE  
\_\_\_COPING WELL

**15. CHECK IF YOU USE THE FOLLOWING APPLIANCES: \_\_\_\_\_NONE**

\_\_\_WALKER\_\_\_CANE \_\_\_CRUTCH \_\_\_WHEELCHAIR \_\_\_BRACE\_\_\_NECK COLLAR

**16. RADIOLOGICAL STUDIES:**

HAVE YOU HAD ANY OF THE FOLLOWING DONE ?

\_\_\_\_\_BONE X-RAY\_\_\_\_\_EMG/NCS\_\_\_\_\_CAT SCAN  
\_\_\_\_\_MRI\_\_\_\_\_MYELOGRAM \_\_\_ OTHER\_\_\_\_\_

**17. IF YOU HAVE HAD ANY OF THE FOLLOWING, PLEASE CHECK WHICH COLUMN APPLIES:**

	NO	YES	DATES	DID IT HELP (YES/NO)	DURATION OF PAIN BENEFIT?
NERVE BLOCKS (INJECTIONS)	___	___	_____	_____	_____
ELECTRICAL STIMULATION (TENS)	___	___	_____	_____	_____
PHYSICAL THERAPY	___	___	_____	_____	_____
MANIPULATIONS	___	___	_____	_____	_____
BIOFEEDBACK/HYPNOSIS	___	___	_____	_____	_____
ACUPUNCTURE	___	___	_____	_____	_____
PSYCHOTHERAPY/PSYCHIARTY	___	___	_____	_____	_____

**18. PAST SURGICAL HISTORY: \_\_\_\_\_**

**19. PAST MEDICAL HISTORY: \_\_\_\_\_**

**20. LITIGATION HISTORY: \_\_\_\_\_Yes \_\_\_\_\_No**

**21. ALLERGIES: \_\_\_\_\_**

**22. LIST MEDICINES YOU ARE TAKING & HAVE TRIED IN THE PAST FOR PAIN:**

MEDICATION	REASON FOR STOP TAKING IT
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____

**23. SOCIAL HISTORY: \_\_\_\_\_**

**Smoking**\_\_Yes\_\_No, **Alcohol**\_\_\_Yes\_\_No, **Substance Abuse**\_\_\_Yes\_\_No

**PATIENT STOPS HERE**