LINCOLN.B. PAIN CLINIC, LTD.

COMPASSIONATE PAIN MANAGEMENT.

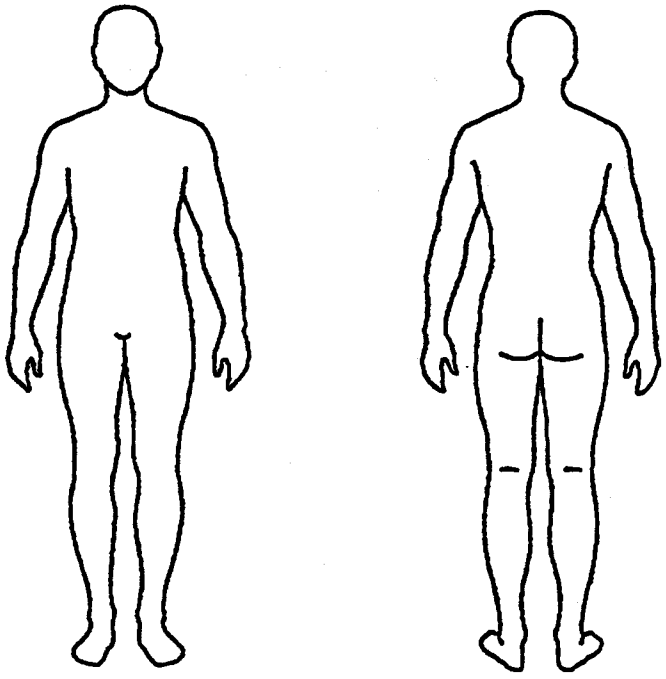
INTERVENTIONAL SPINE & JOINT CARE·
PHYSICAL MEDICINE AND REHABILITATION·
600·N·COURT SUITE #200, PALATINE, IL·60067

PAIN CLINIC:INITIAL PATIENT HISTORY/ASSESSMENT

Patient Name: _____ **Age**_____

Height_____ Weight_____ Sex: Male____ Female ____

Vitals: Temp_____ BP_____/_____ Pulse_____ Resp_____
Who referred patient to this pain clinic_____
Primary Care Physician:_____
Please indicate in this diagram where your pain occurs by shading the painful area(s)



Front Back

In what part of your body did your pain begin? _____

When did the pain first start (approximate date)?_____

How did your pain start?

Accident at work Accident at home Motor vehicle accident

Following surgery Following an illness The pain just began

Other reason

What is your occupation?:_____

Do you have a lawyer /involved in litigation because of your pain or injury ? Yes No

Is this a Workers Compensation/ Auto Accident Case Yes No

If yes please give claim number/ Adjuster_____

How would you describe your pain? (Check all that apply)

Pricking Throbbing Dull Aching Sharp/Stabbing

Pulling Burning Numbness Tingling Shooting

Please mark your pain level at this time, 10/10 being the worst pain imaginable and 0/10 being no pain at all_____ now ____ at its worst____on average____goal for pain relief.

1 2 3 4 5 6 7 8 9 10

When is your pain worst? Walking Standing Bending
Other_____
Is your pain _____ constant _____ intermittent.
What relieves your pain?_____
Has the patient received steroid injections in the past ?_____No ____Yes: If yes, when_____ Did it help?_____Yes _____No.
Has the patient tried physical therapy____Yes_____No. If yes did it help ?_____
Have you consulted a pain specialist in the past ? Yes No
Have you had X-rays, CT scans or MRI's of the cervical, lumbar, thoracic spine or any other joints ? If yes please attach your MRI reports_____
Have you had Electromyography(EMG) or Nerve Conduction Studies(NCS)_____

If yes, Who? and please describe what you were treated for and any procedures or pain medications tried,_____

_____

Have you ever had a psychological or a psychiatric evaluation or treatment?
Yes No
If yes, state the diagnosis and treatment:_____

Do you take any blood thinners, anticoagulants. Aspirin, Plavix, Coumadin, Alleve, Advil, Ibuprofen, heparin, lovenox_____

_____

Prior treatments (check all that apply)	**Helpful**	**Not Helpful**
Surgery		
Spinal injections		
TENS		
Physical Therapy		
Biofeedback/Relaxation Therapy		
Professional Psychological Support		
Chiropractic Manipulation		
Other_____		

General Review of Systems:

A) Any symptoms of heart trouble? _____Yes_____No

_____ Chest pain _____palpitations _____unable to lay flat _____ankle swelling

B) Any breathing problems? _____Yes _____No

_____Shortness of breath_____chronic cough _____home oxygen required

C) Any stomach / intestinal problems? _____Yes _____No

_____Heartburn _____Reflux _____Spasms Other _____

D) Any neurological problems? _____Yes _____No

_____Seizures _____Epilepsy _____Numbness _____Loss of memory
_____Stroke_____Bowel incontinence _____Bladder incontinence

E) Ambulatory? ____Yes ____Yes, with cane, wheelchair or walker ____No

F) Smoker? _____Yes _____No
If yes, number of packs per day _____ for how many years _____

Use of alcohol? _____

Past Medical Problems (please circle): Hypertension, diabetes, heart disease, kidney disease, lung disease, cancer, others please list_____
_____,

_____,

_____

Drug Allergies? _____
Are you allergic to seafood/iodine/ shellfish?_____
Are you employed/retired/ disabled_____

What are your expectations from the pain clinic?_____
_____

Current Medication List:_____,
_____,
_____,
_____,
_____,
_____,
_____.

List all past surgeries:_____,
_____,
_____;
_____,
_____.

PLEASE HAVE ALL YOUR RELEVANT MEDICAL RECORDS, REFERRAL LETTERS, RADIOLOGICAL REPORTS FROM YOUR PRIMARY CARE PHYSICIAN AND REFERRING PHYSICIAN FAXED TO THE OFFICE BEFORE YOUR VISIT. THANK YOU.