

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

CHIEF COMPLAINT: Briefly state what issue you would like me to address today?

**HISTORY OF PRESENT ILLNESS:**

1. **START & CIRCUMSTANCES OF PAIN-** When did pain start and what was the cause?(i.e. motor vehicle accident, fall, sports injury, etc.) \_\_\_\_\_

2. **LOCATION-** Where is the majority of your pain? \_\_\_\_\_

3. **QUALITY-** What kind of pain are you having? Please check [√] all that apply.

- Burning       Pins & Needles     Electric       Dull Aching  
 Numbness     Aching             Stabbing       Shooting       Other \_\_\_\_\_

4. **DURATION/TIMING-** Describe your pain pattern and time when it occurs. Please [√] check all that apply.

- Morning       Mid-Day       Evening       Night  
 Intermittent     Continuous     Sporadic

5. **SEVERITY-** Please place an "X" on the lines below indicating the level of pain.

What is your pain level **TODAY**?      What is your **LEAST** level of pain?      What is your **WORST** level of pain?  
None \_\_\_\_\_ Severe      None \_\_\_\_\_ Severe      None \_\_\_\_\_ Severe

6. **Which is worse? Please circle one.**      Back/Neck Pain      or      Leg/Arm Pain

7. **Please list any associated signs and symptoms-** (i.e. numbness/weakness/blurred vision)

8. **What does your pain prevent you for doing?** (i.e. sleeping/house or yard work/recreational activities/job duties)

9. **MODIFYING FACTORS-** Please indicate any of the following treatments you have had by checking [√] the effect

TREATMENT	HELPED	MADE WORSE	NO EFFECT
Hot Packs			
Ultrasound			
Ice			
Massage			
TENS Unit			
Back School			
Strengthening Exercises			
Aerobics (exercise, bike, ect.)			
Traction			
Bed Rest			
Chiropractic Treatment			
Trigger Point Injections			
Epidural Injections			
Facet Injections			
Back Brace			
Acupuncture			
Anti-Inflammatory Meds			
Narcotic Pain Medication			
Muscle Relaxant Medication			
Anti-Depressant Medication			

**REVIEWS OF SYSTEM-** PLEASE CHECK [✓] ALL THAT APPLIES.

**GENERAL**

- Fever
- Weight Loss
- Fatigue

**RESPIRATORY**

- Asthma
- COPD
- Emphysema
- Cough

**MUSCULOSKELETAL**

- Arthritis
- Muscle pain
- Joint Pain/ Location

**PSYCHIATRIC**

- Depression
- Anxiety
- Mood Swings
- Other\_\_\_\_\_

**EYE,EAR,NOSE,THROAT**

- Blurry Vision
- Glaucoma
- Cataracts
- Dental Procedure last week
- Hearing Difficulty
- Swallowing Difficulty
- Speech Difficulty

**GASTROINTESTINAL**

- Ulcers
- Reflux
- Liver Disorder
- Blood in Stool
- Hiatal Hernia
- Bowel Leakage /incontinence

**SKIN**

- Skin Breakout
- Rash
- Burns
- Skin Grafts

**ENDOCRINE**

- Diabetes
- Thyroid Disorder

**BLOOD/LYMPHATIC**

- Bleeding/Bruising Disorder
- Blood Clots
- Anemia

**CARDIOVASCULAR**

- Heart Disease
- Angina
- Pacemaker
- Irregular Heart Beat
- High Blood Pressure

**GENITOURINARY**

- Prostate Problems
- Kidney Stones
- Bladder Infections
- Incontinence

**NEUROLOGIC**

- Memory Loss
- Sensory Loss
- Weakness
- Coordination Problems
- Falls

**ALLERGIES**

Do you have any of the following allergies? Please check [✓] all that applies.

- Shellfish
- Iodine
- Steroids
- Local Anesthetics (i.e. Lidocaine)

Please List any allergies you have to medications and the reaction.

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**PAST MEDICAL AND SURGICAL HISTORY**

Please list active medical problems and the physician following you for the problem.

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Please list past surgical procedures including date and physician who performed the procedure.

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**MEDICATIONS**

Please list all of the medications that you are currently taking:

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**FAMILY HISTORY**

Mother:       Living       Deceased, Due to: \_\_\_\_\_ Age: \_\_\_\_\_

Father:       Living       Deceased, Due to: \_\_\_\_\_ Age: \_\_\_\_\_

Siblings:     Living       Deceased, Due to: \_\_\_\_\_ Age: \_\_\_\_\_

**Please check [✓] any of the following conditions that run in your family:**

- Headaches       Migraines       Arthritis       Neck/Back Pain
- Fibromyalgia     Lupus       Drug Dependency     Drug Abuse
- Anxiety       Schizophrenia     Suicide       Depression
- Alcoholism

**SOCIAL HISTORY**

Do you drink alcohol?  Yes     No    If yes, how much and how often? \_\_\_\_\_

Do you smoke?       Yes     No    If yes, how much and how often? \_\_\_\_\_

Do you use drugs?     Yes     No    If yes, what type and how much? \_\_\_\_\_

Are you married?     Yes     No     Other (divorced, widowed, etc) \_\_\_\_\_

Do you have children?  Yes     No    If yes, How many? \_\_\_\_\_

Please list any hobbies: \_\_\_\_\_

Do you work?       Yes     No    Occupation (present or former) \_\_\_\_\_



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Physical Medicine and Rehabilitation Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness

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Pins & Needles

o o o o o

Burning

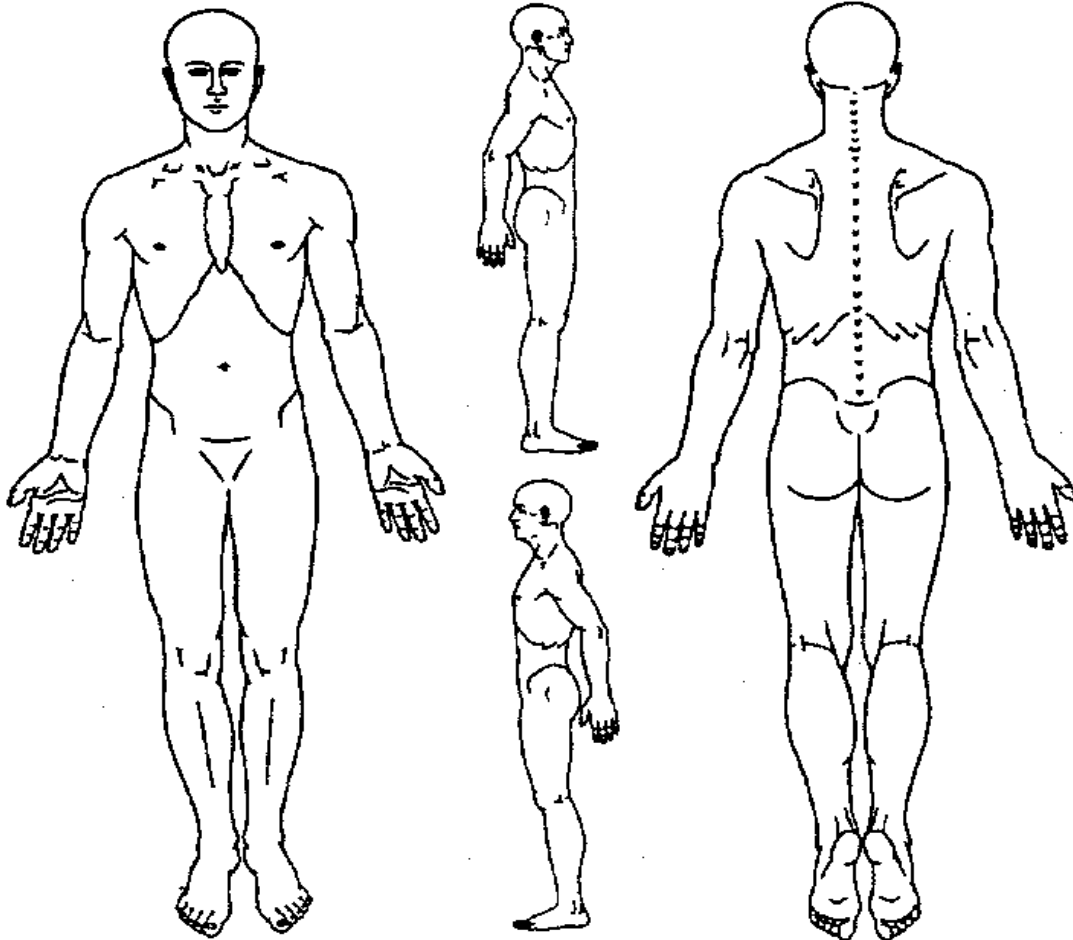
^ ^ ^ ^ ^

Aching

x x x x

Stabbing

⊗ ⊗ ⊗ ⊗



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