MOUNTAIN VIEW
HEADACHE AND SPINE
INSTITUTE

Medical/Clinical History

Your Name: ____ Date of Birth: _________________

Primary reason for today's visit: ________________________ Height: _______ Weight: _______

Preferred Pharmacy:_________________________________ Address: _______________________

Pain Scale

Where is your **worst area** of pain centered? ____

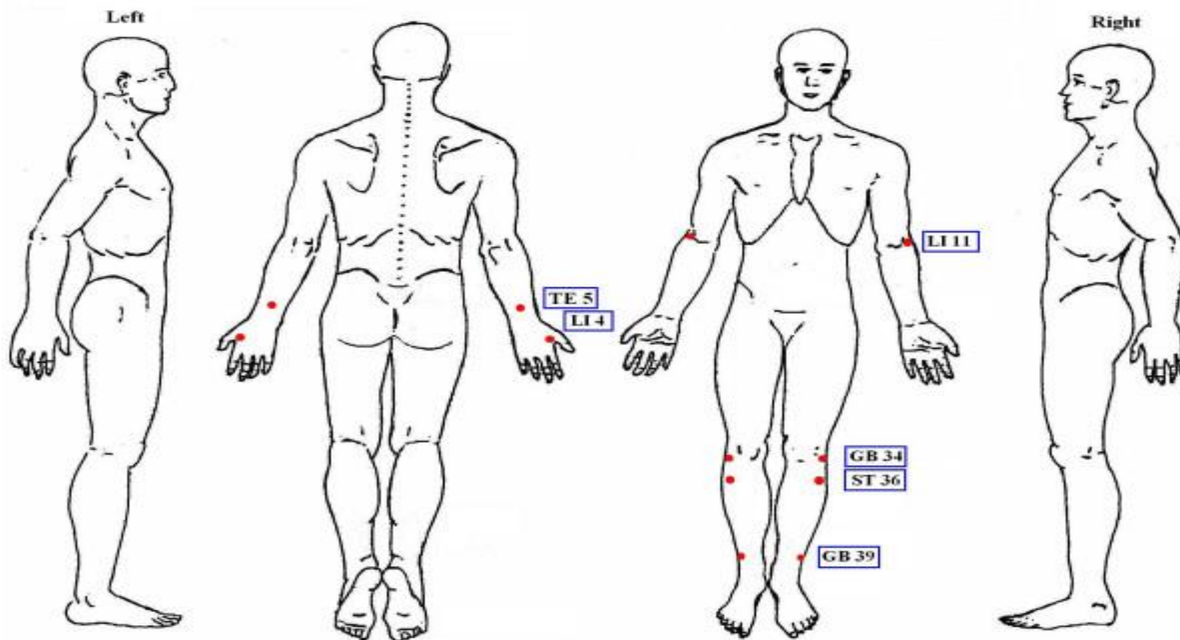
What number on the pain scale (0-10) best describes your **pain right now**?

What number on the pain scale (0-10) best describes your **worst pain?**

What number on the pain scale (0-10) best describes your **least pain?**

Pain Location

Use this diagram to circle the location of your pain.



Onset of Symptoms

Approximately when did the pain begin? ____

What caused your current pain episode? ____

Is your pain the result of a Motor Vehicle Accident or Personal Injury? YES / NO

How did your current episode begin? GRADUALLY / SUDDENLY

Since your pain began, has it changed? DECREASED / INCREASED / REMAINED THE SAME

Pain Description

What aggravates your pain? (Circle all that apply.)

Bending/ change in weather/ driving/ going downstairs/ going upstairs/ increased activity/ lifting objects/ lying flat/ movement/ sitting/ standing/ walking/ stretching/ other:

____

What helps alleviate your pain? (Circle all that apply.)

Bending/ change in weather/ driving/ going downstairs/ going upstairs/ increased activity/ lifting objects/ lying flat/ movement/ sitting/ standing/ walking/ stretching/ other:

____

Circle all the following that describe your pain:

Numbness, Burning/hot, Cramping, Dull, Shooting, Stabbing/sharp, Tingling/pins, Throbbing, Aching, Shock-like, Spasming, Squeezing.

Pain Frequency

What word best describes the frequency of your pain? CONSTANT / INTERMITTENT

When is your pain at its worst? MORNING / DURING THE DAY / EVENINGS / NIGHTTIME

Diagnostic Tests and Imaging

- MRI of the __________________ Date: _____________ Facility: ______________________
- X-ray of the _________________ Date: _____________ Facility: ______________________
- CT of the ___________________ Date: _____________ Facility: ______________________
- EMG/NVC study of the _______ Date: _____________ Facility: ______________________
- Ultrasound of the ____________ Date: _____________ Facility: _______________________
- Other diagnostic testing: ____

Current Medications

Are you currently taking any aspirin, blood thinners or anticoagulants? YES / NO

If yes, which ones? COUMADIN / PLAVIX / LOVENOX / AGGRENOX / OTHER:

____

Please list all medications you are **CURRENTLY** taking. Attach an additional sheet if necessary.

Medication name	Dose	Frequency

PREVIOUS Medications Tried

Circle any medications tried in the **PAST**

Over the counter medication:

ASPIRIN - ACETAMINOPHEN/TYLENOL - ADVIL/MOTRIN/IBUPROFEN - ALEVE/NAPROXEN EXCEDRIN

Prescription Anti-Inflammatories:

IBUPROFEN - NAPROXEN - DICLOFENAC/VOLTAREN - MELOXICAM/MOBIC - CELECOXIB/CELEBREX - KETOROLAC/TORADOL - ETODOLAC - INDOMETHACIN - PIROXICAM

Muscle Relaxers:

FLEXERIL/CYCLOBENZAPRINE - ROBAXIN/METHOCARBAMOL - TIZANIDINE/ZANAFELX – SOMA/CARISOPRODOL – BACLOFEN – SKELAXIN/METAXALONE – ORPHENADRINE/NORFLEX – LORZONE/CHLORZOXAZONE

Nerve Pain medications:

GABAPENTIN/NEURONTIN – PREGABLIN/LYRICA – DULOXETINE/CYMBALTA – AMITRIPTYLINE/ELAVIL – NORTRIPTYLINE/PAMELOR – OXCARBAZEPINE/TRILEPTAL – TOPIRAMATE/TOPAMAX

Opiates: Short acting:

TRAMADOL/ULTRAM – TYLENOL W/ CODEINE – HYDROCODONE/VICODIN – OXYCODONE/PERCOCET – DILAUDID/HYDROMORPHONE – IMMIDIATE RELEASE MORPHINE – OPANA IR **Extended Release:** BUTRANS PATCH – FENTANYL/DURAGESTIC PATCHES – MS CONTIN/MORPHABOND/MORPHINE ER – OXYCONTIN – OPANA ER – METHADONE

Opiate included constipation:

MIRALAX – DOCUSATE – SENOKOT – COLACE – MOVANTIK – AMITIZA – LINZESS – RELISTOR

Pain Treatment History

Mark all the following pain treatments you have undergone **prior** to today's visit:

CHIROPRACTIC / NEUROSURGEON / PAIN MANAGEMENT / PHYSICAL THERAPY / RHEUMATOLOGY / ACUPUNCTURE / MASSAGE

- Discogram – (circle all levels that apply) Cervical/ Thoracic/ Lumbar
- Epidural Steroid Injection – (circle all levels that apply) Cervical/ Thoracic/ Lumbar
- Joint Injection- Joint(s) ____
- Medial Branch Blocks or Facet Injections- (circle all levels that apply) Cervical/Thoracic/Lumbar
- Nerve Blocks – Area/Nerve(s) ____
- Radiofrequency Ablation- (circle all levels that apply) Cervical/ Thoracic/ Lumbar
- Spinal Column Stimulator- (circle one) Trial Only/ Permanent Implant- Which company ____
- Trigger Point Injection- Where? ____
- Vertebroplasty/ Kyphoplasty- Level(s) ____
- Other: ____
- Other: ____
- **I have NOT had any prior treatments for my current pain complaints**

Allergies

Do you have any known allergies? YES / NO

If so, please list all medications you are allergic to:

Medication Name **Allergic Reaction Type**

____
____
____
____
____
____
____
____
____
____
____

Past Medical History/ Problem List

Cardiovascular/Hematologic

- Anemia
- Heart Attack
- Hypertension
- Mitral Valve Prolapse
- Pacemaker/Defibrillator
- Coronary Artery Disease
- High Cholesterol
- Poor Circulation
- Stroke

Musculoskeletal

- Amputation/ Phantom Limb Pain
- Bursitis
- Carpal Tunnel Syndrome
- Chronic Low Back Pain
- (CRPS)
- Spinal Cord Injury
- Traumatic Brain Injury (TBI)
- Chronic Joint Pain
- Chronic Neck Pain
- Fibromyalgia
- Joint Injury ________________
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis
- Tennis Elbow
- Schizophrenia
- Seizures
- Reflex Sympathetic Dystrophy (RSD) /Chronic Reginal Pain Syndrome
- Vertebral Compression Fracture

General Medical

- Cancer- Type _______
- Diabetes- Type _______
- HIV/AIDS

Respiratory

- Asthma
- Bronchitis
- COPD
- Pneumonia
- Tuberculosis
- Valley Fever

Gastrointestinal

- Bowel Incontinence
- Constipation
- GERD

Head/Eyes/Ears/Nose/Throat

- Glaucoma
- Migraines
- Head Injury

Hepatic- list:

Hepatitis **A / B / C ACTIVE/INACTIVE/UNSURE**

- Hyperthyroidism
- Hypothyroidism

Other: ________________

- **I HAVE NO SIGNIFICANT MEDICAL HISTORY**

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type or other pertinent details:

Abdominal Surgery

- ❑ Gallbladder removal ______________________
- ❑ Appendectomy ________________________
- ❑ Other ________________________

Joint Surgery

- ❑ Hip ________________________
- ❑ Knee ________________________
- ❑ Shoulder ________________________

Female Surgeries

- ❑ Caesarean section ________________________
- ❑ Hysterectomy ________________________
- ❑ Laparoscopy ________________________
- ❑ Ovarian ________________________
- ❑ Other ________________________
- ❑ Other ________________________

Spine/Back Surgery

- ❑ Discectomy (levels) __________________
- ❑ Laminectomy________________________
- ❑ Spinal Fusion (levels) _________________
- ❑ Other ______________________________
- ❑ Other ______________________________

Other Common Surgeries

- ❑ Hemorrhoid surgery_________________

Heart Surgery

- ❑ Aneurysm repair ________________________
- ❑ Stent placement ________________________
- ❑ Valve replacement ________________________
- ❑ Other ________________________

- ❑ Thyroidectomy ______________________
- ❑ Tonsillectomy ________________________
- ❑ Vascular surgery _____________________
- ❑ Hernia repair_________________________

Please list any other surgeries and dates

____
____
____
____

❑ I HAVE **NOT** HAD ANY SURGICAL PROCEDURE DONE

Hospitalizations

Please list any **RECENT** hospitalizations:

Month/Year Reason

____

____

____

Family History

Mother alive / deceased illnesses:

____

____

Father alive / deceased illnesses:

____

____

- ❑ **NO SIGNIFICANT FAMILY HISTORY / I AM ADOPTED**

Social History

Tobacco use: Current smoker? Yes/ No Start? ______ How often? Everyday / Somedays

How many a day? 5 or less / 6-10 / 11-20 / 21-30

Former smoker? Yes / No Start? _______________ Stop? ___________________

Nonsmoker? Yes / No

Illegal Drug Use: Yes / No If yes, please list:____

Caffeine intake? None / 1-2 cups a day / 2-3 / 3-4 / more than 4 cups a day

Current Marijuana use? Yes / No

Do you drink alcohol? Yes / No / Daily / Socially / Rarely

Occupation: ____

Marital Status (circle one): Single / Married / Divorced / Widowed

Review of Systems

General: Change in appetite / Chills / Fatigue / Fever / Headache / Lightheadedness / Night sweats / Sleep disturbance / Weight gain / Weight loss

Ophthalmologic: Blurry vision / Change in vision / Double vision / Eye pain

ENT: Decreased hearing / Decreased sense of smell / Difficulty is swallowing / Dry mouth / Ear pain / Nasal congestion / Nosebleed

Endocrine: Cold intolerance / Dizziness / Excessive sweating / Excessive thirst / Frequent urination / Hair loss / Heat intolerance / Hot flashes / Weakness

Respiratory: Chest pain / Chest tightness / Chronic cough / pain with inspiration / shortness of breath

Cardiovascular: Chest pain / Chest pain at rest / Difficulty laying flat / Dizziness

Gastrointestinal: Abdominal pain / Blood in stool / Constipation / Decreased appetite / Diarrhea / Heartburn / Nausea / Vomiting

Hematology: Anemia / Easy bleeding / Easy bruising / Fever / Prolonged bleeding

Musculoskeletal: Arthritis / Back pain / Joint stiffness / Leg cramps / Muscle spasms / Neck pain / Pain in shoulder(s) / Painful joints / Sciatica / Swollen joint(s) / Trauma to arm(s) / Trauma to hip(s) / Trauma to knee(s) / Trauma to ankle(s) / Weakness

Neurologic: Balance difficulty / Difficulty speaking / Dizziness / Fainting / Headache / Irritability / Loss of strength / Low back pain / Memory loss / Paralysis / Seizures / Stroke / Tic / Tingling / Numbness / Tremor

Psychiatric: Anxiety / Delusions / Depressed mood / Difficulty sleeping / eating disorder / Loss of appetite / Mental or physical abuse / Mood disorder / Nervous breakdown

Medical History and Authorization to Proceed with Treatment

I certify that the above is true and accurate to the best of my knowledge.

Signature: ________________________________ Date: _________________________