FLORIDA PAIN AND REHABILITATION CENTER

www.flpnr.com

Lady Lake	Ocala	Lake City
918 Rolling Acres Road	1910 SW 18th Court	440 SW Perimeter Glen
Unit 2	Suite 200	Lake City, FL 32055
Lady Lake, FL 32159	Ocala, FL 34471	Phone: 386-719-9663
Phone: 352-751-6582	Phone: 352-629-7011	Fax: 866-300-2394
Fax: 866-330-7528	Fax: 866-592-7773	

Patient Initial Visit Information Sheet

Date:

Last Name: ____________________ First Name: ______________________Middle Name: ____________

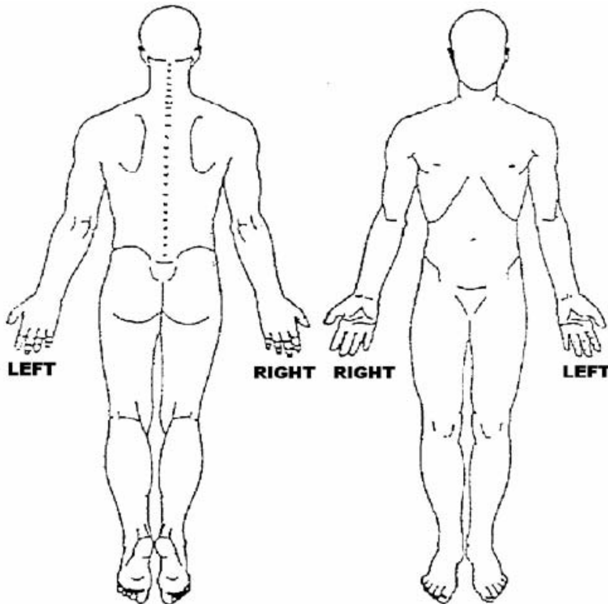
Age: ________ Gender: M □ F □ Right handed □ Left handed □

Referring Physician: _________________________ Primary Care Physician: _________________________

Address: _______________________________ City: __________________ State: _______Zip:__________

Main reason for the visit: ______________________________

Pain Diagram
On the picture below, please mark all the area of your pain:



1. When did your pain start? _
2. Please describe how your pain started:
3. Did you fall? □ yes □ no. If yes, Where ?

   How did you fall? _____________________

   Did you lift/push anything heavy? □ yes □ no

   If yes, where ____ ? What it was ___ ?

   How heavy______ ?
4. Was this a work related injury? □ yes □ no.
5. Did your pain start slowly without any injury?

   □ yes □ no.

   Where is your main pain now?_________

5. Is your pain related to a motor vehicle accident? □ yes □ no. If yes, please answer following questions. Otherwise please go to question 4 directly.

a. Date of the accident __________

b. Were you □ the driver or □ a passenger in front or □ a passenger in the back row

c. Were you wearing a seat belt? □ yes □ no

d. At the time of accident, was your vehicle: □ stopped or □ moving and □ hit another vehicle or hit by another vehicle

e. Were you hit: □ head on, or at □ driver side, □ passenger side, □ back of the vehicle, in a speed of about _MPH?

f. How bad was your vehicle damaged? □ mildly □ severely or □ towed

g. Was the airbag deployed? □ yes □ no

h. Did you have an episode of loss of consciousness? □ yes □ no. If yes, how long? ______

i. Did you go to the emergency room?: □ yes □ no If yes, Which hospital? _______

j. Were you admitted into the hospital? □ yes □ no. If yes, which hospital and how long did you stay? ____

k. Did you have any fractures? □ yes □ no. If yes, which bone(s)?____________

l. How long after the accident did your pain start? ____________________________

m. Do you have a history of any other motor vehicle accidents before this one? If yes, please *Explain*: ____

n. Did you have any pain prior to the accident? □ yes □ no.
If yes, were was the pain?____

6. Previous treatment for your current pain

Have you ever been to another pain clinic? □ Yes □No

If yes, Name of the clinic ____________________________ Dr.'s name_______________

Name of the clinic ___________________________________ Dr.'s name_______________

Name of the clinic ___________________________________ Dr.'s name_______________

Please list all the pain medications you took before but for some reasons you have stopped (e.g. Ibuprofen, Naproxen, Motrin, Advil, Predinison, Medrol-dose pack, Vioxx, Celebrex, Bextra, Valium, Flexeril, Baclofen, Neurontin, Tegretol, Elavil, Celexa, Darvon, Darvocet, Roxicet, Percocet, Oxycodone, Oxycontin, Kadian, Ultram, Ultracet et al).

Name	Dose	Effective?	Side effect	Reasons to stop

Have you had occupational therapy for pain? How long? __________________ Helpful? ____
Have you tried acupuncture for pain relief? Was this helpful? Yes_ No_ Have you seen a chiropractor for pain relief? Was this helpful? Yes_ No_
If yes, who was the chiropractic doctor? __________________________________
Have you had any previous injections for your pain?
If yes, what kind of injection? _______________________________
Did they help? ____
No Have you had previous surgery for pain your pain? *If yes,* How many _________________
Who was the doctor? ___________________________
Name of the surgery? ___________________________
When was it done? ____________________________
Did the surgery help? □ yes □ no
How much pain relief did you have from the surgery? ______________________ (0 to 100%)

7. Current pain level: (no pain: 0; worst pain: 10)

Pain score right this moment: _ Average Pain score over the last 24 hours;

Pain score without medication: Pain score with medication: ____

8. Pain quality: Check the boxes that best describe what your pain feels like.
□ Throbbing □ Shooting □ Stabbing □ Sharp □ Cramping
□ Burning □ Tingling □ Aching

9. Pain pattern:
□ Continuous □ Rhythmic □ Comes and goes

10. What can make your pain worse?
□ Sitting □ Standing □ Walking □ lifting □ Cough/sneeze □ lying flat on back
□ Others: ______

11. What can make your pain better?
□ Sitting □ Lying flat on back □ Others:

12. Do you have any of following symptoms when you have pain?
□ Nausea □ Vomiting □ Visual disturbance□ Weakness □ Incontinence
□ Shortness of breath □ Others: ________________________

13. Do you have difficulty sleeping because of pain? □ Yes □ No
How many hours a day on average can you sleep recently?

14. Have you ever been treated for a different pain condition? □ Yes □ No
If yes, please describe where and when: ____

13. Past Medical History
Please circle any of the following problems that you currently have/ had:

1. High blood pressure
2. Diabetes
3. Heart Murmur
4. Arrhythmia
5. Heart attack
6. Chest pain
7. Asthma
8. Tuberculosis
9. Stomach ulcers
10. Hepatitis
11. HIV infection
12. Seizure
13. Stroke
14. Cancer
15. Kidney infection/stone
16. Thyroid disease
17. Bleeding disorders
18. Depression
19. Psychosis
20. Others ________________________

14. Past Surgical History: *Please list all previous surgeries* **Date (MO/YR) Name of the surgery(ies)**

15. Current pain medications
Please list all the pain medications you are taking currently (including any nonprescription medications such as Tylenol, Bengay etc..) ____

Name	*Dose (mg)*	*How do you take (example -one tablet twice daily)*	*Is it effective?*	*Any side effect?*

16. Current Other medications
□ Yes □ No Are you currently taking any medications for other non-pain related health conditions?
If yes, please list (be sure to include nonprescription, eye drops, topical drugs such as vitamins)

Name	*Dose (mg)*	*How do you take (example-one tablet twice daily)*

17. Please list any drug allergy

Name of Medication	Reactions

18. Family History

Do you have a family history of (Circle all that apply)?

1. Diabetes 2. Tuberculosis 3. Heart attacks
4. Rheumatoid arthritis 5. Back problems 6. Others:_________________

19. Social History

Are you currently: (circle one) Single Married Widowed Divorced Separated
Do you smoke cigarettes? *If yes,* packs per day for_____years? Quit ________
Do you drink alcohol beverages? *If yes,* how much per day? ___________
Have you *ever* used Marijuana, methamphetamine or cocaine? ______________
Are you currently working?:
How many hours a day? (circle one) 0 1 2 3 4 5 6 7 8 more
If not, when was your last work? Date: _________________
Is this a worker's compensation case?
Are you involved in a lawsuit related to your pain condition?
Are you interested to return to work soon, if you are not working currently?

20. Review of System

Have you had any of the following symptoms recently?

Constitutional: Dfever Dweight loss Dsleep difficulty
Cardiovascular: Dchest pain Dshortness of breath
Respiratory Dcough Dwheezing Dasthma Dbreathing difficulty
Gastrointestinal: Dnausea Dvomiting Dabdominal pain Dconstipation
Genitourinary: Durine incontinence Dpain on urination Dimpotence
Female reproduction: Dpregnant Dabnormal bleeding
Skeletal muscle: Dback pain Dneck pain Djoint pain Djoint swelling
Neurological: Dheadache Darm weakness Dleg weakness Dgait unsteadiness
Vision: Dvisual difficulty Dglaucoma Deye pain
ENT: D ear infection Dear pain
Skin: Drash Dulcer Dskin cancer Dinfection Dhypersensitivity Dcolor change Dtemperature change
Immunology: D Rheumatoid arthritis D SLE
Psychological: Ddepression Danxiety Dpanic attack Dsuicidal ideation

Stop here. Thank you very much for your help. You doctor will review all the information with you soon. Following sections are for the nurse and doctor to finish.

Physical Examination:

T: **P:** **R:** **BP:** **Weight:** **Height:**

Mental Status:

Spine: **Tenderness:**

Right Left Left Right

Skin:

HEET:

Neck:

Cardiovascular:

Lungs:

Abdomen:
Extremities:

Spurling's Sign L __ Right ____
Range of motion: Neck ___ Back
Scoliosis ________
Patrick's test L __ Right ____
SLS test L __ Right __
Fortin's Test L __ Right ____
SLR test L __ Right ____

Cranial Nerves:

Sensory: Decreased sensation to pin prick at
Left:__ **Right:**

Motor: Weakness of
Left **Right**

EHL ___
TA _
TP__
PL__
PB__
EHL__
TA__
TP__
PL__
PB__

Reflex: Gait:

Test results:

EMG
MRI
Blood test

Impression:

1.
2.
3.

Plan:

1. **Medications:**

2. **Physical therapy/IDD therapy/ Massage therapy/Acupuncture:**

3. **Interventional pain management**

4. **Surgery**

5. **Activity**

6. **Working status**

PA/NP **____** ***Physician***