Dr. Evans' Patient History

Date: ____/____/_______

Please fill out completely.
Shade like this: ■

Med Record # ____________________

Name: ____ Age ___________yrs. DOB______________________

Height: _____ft _____in **Weight:** _____lbs **Sex:** Male Female **Are you or could you be pregnant?** Yes No

History of Current Spine/ Joint Problems

Date of Injury:____

List your chief complaints or main problems with the most severe first:

1.____

2.____

3.____

Describe all details of any accident, incident or the way these problems began:

____

____

____

Current Symptoms

What time of the day is your pain at its worst? Morning Afternoon Evening Night Not Applicable

Does the pain wake you up at night? Yes No

In the past six months have you experienced: Fever Weight Loss__________lbs Chills Night Sweats

How would you describe you pain? Constant Constant, but worse with activity Intermittent (comes and goes) Intermittent, but worse with activity

Do you have full control for your bladder? Yes No

Do you have full control of your bowels? Yes No

What Treatments have you tried for this condition?

Nothing Decrease Activity Physical Therapy. If so, when did you start?_______________________________

Exercise Acupuncture Chiropractor Bracing Ice

What medications have you tried for this condition? (OTC, Rx) : ___________________________________

____

Other:____

INJECTIONS

Have you ever had a spinal injections (epidurals, facet injections, rhizotomies, etc) Yes No

If so, what types of injections have you had and at what level(s)? ____________________________________

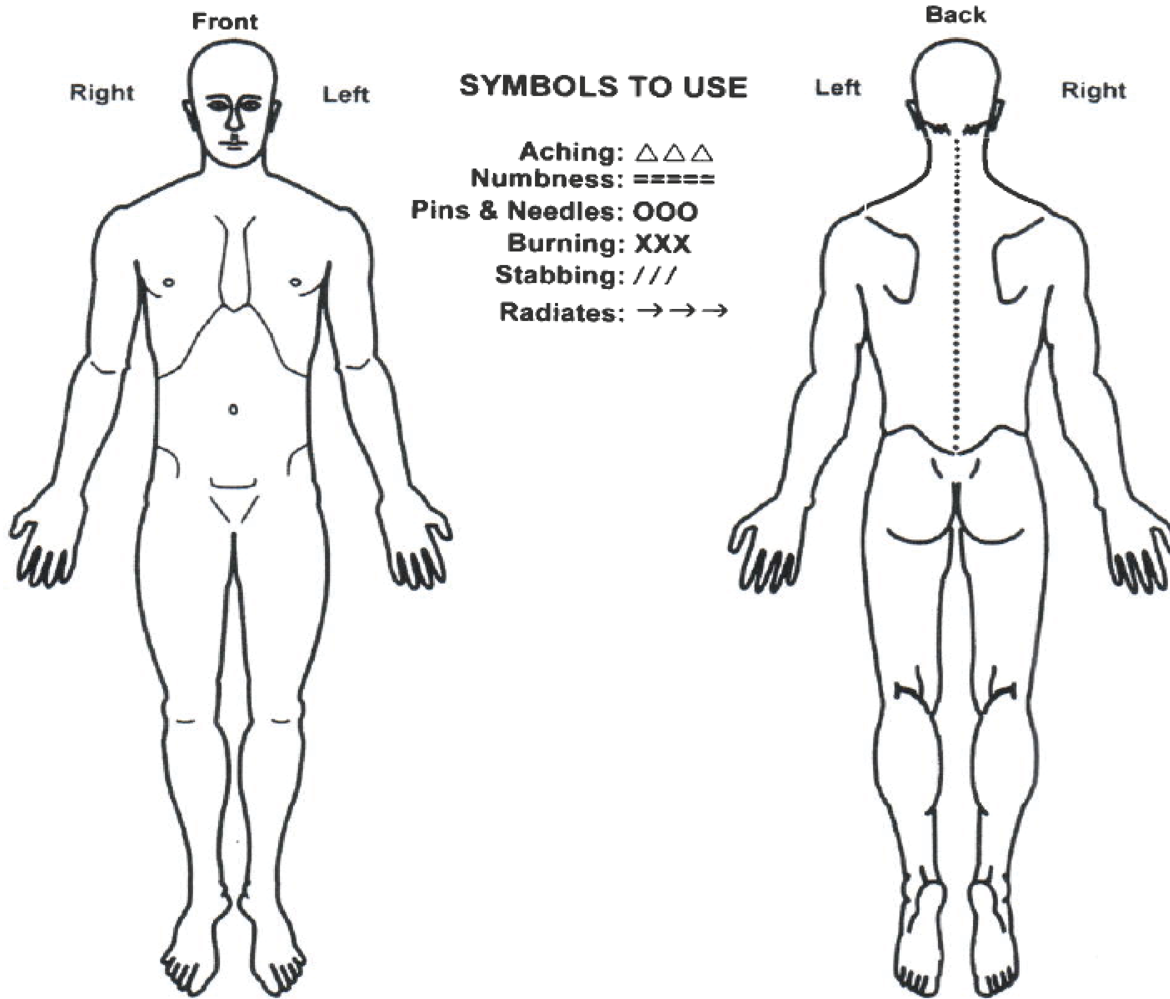
What type of injection and when was your last spinal injection(s)? ____________________________________

What % of relief did it provide you for the FIRST 3 HOURS? ____

How long did the relief last after that? ____

Patient Pain Drawing

Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates, include all affected areas.



For each area of your body, please mark where your symptoms (pain, numbness, weakness, etc.) exist on "average" and at the "worst." ZERO is no symptoms - > TEN is the worst pain of your life

Current **NECK** pain **Average** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Worst** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	Current **Low Back** pain **Average** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Worst** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Current **SHOULDER** pain **Average** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Worst** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	Current **SI** pain **Average** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Worst** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Current **ARM** pain **Average** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Worst** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	Current **Buttock** pain **Average** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Worst** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Current **MID BACK** pain **Average** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Worst** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	Current **Groin** pain **Average** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Worst** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
	Current **Leg** Pain **Average** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Worst** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Dr. Evans' MIGRAINE history

Please complete if you are seeing Dr. Evans' for evaluation

☐ ***NONE: If no history of migraines/headaches, skip this page***

How long have you had migraines/headaches? ______________________________

How many headaches do you get per month? ______________________________

How many hours do your headaches typically last? ______________________________

Where do you get your headaches? ______________________________

What is the intensity of your headaches? Pain scale 0-10/10: ______________________________

What do you do when you have a headache? ______________________________

What other symptoms do you get with your headaches (nausea, aura, etc)?
____

What medications do you take NOW for your headaches (list any/all)?
____

What medications have you taken in the past that do not work now?______________________________

Have you tried ANY of the following medications or others like them? (please circle)

- ☐ **Rescue Medications/Triptans: Imitrex, Frova, Maxalt, Relpax, Treximet, Zomig, Rizatriptan, Amerge**
- ☐ **Angiotensin-converting enzyme inhibitors/angiotensin II receptor blockers: Losartan, Valsartan, Lisinopril**
- ☐ **Anti-depressants: Amitriptyline, Nortryptiline, Effexor, Paxil, Prozac**
- ☐ **Anti-epileptics: Gabapentin, Lyrica, Topiramate, Valproic Acid, Depakote**
- ☐ **Beta Blockers: Atenolol, Metoprolol/Lopressor, Propanolol/Inderal, Timolol**
- ☐ **Calcium Channel Blockers: Diltiazem, Nifedipine, Verapamil**
- ☐ **Others: Excedrin, Fioricet, Fiorinal, Stadol, Midrin, Cafergot, Butalbital**
- ☐ **Muscle Relaxers**
- ☐ **NSAIDs: Advil, Ibuprofen, Aleve**
- ☐ **Botox Injections**

Others: ______________________________

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