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 ☐ Exercise ☐ Bracing ☐ Ice ☐ Heat

☐ Physical Therapy (Date Started):_____(Stopped/ Last Visit Date:) _____Facility:_____

☐ Chiropractor (Date Started): _____ Acupuncture (Date Started) :_____

Other:_____

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

_____

Have you seen another physician for this problem/injury? (who/when) _____

_____

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)? _____

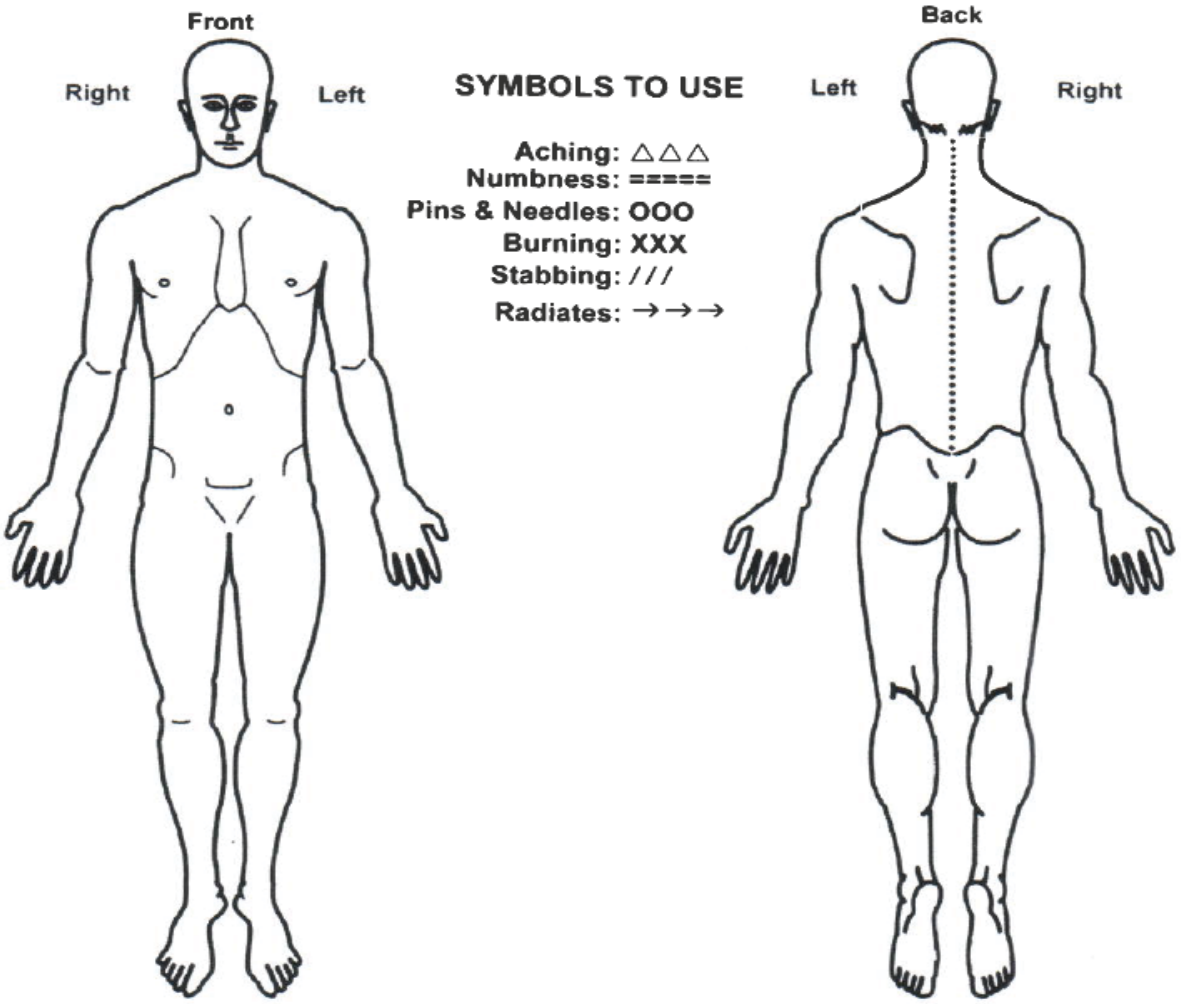
What type of injection and when was your last spinal injection(s)? _____

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
Date Started: _____ Ended:_____

Angiotensin-converting enzyme inhibitors/angiotensin II receptor blockers: Losartan, Valsartan, Lisinopril
Date Started: _____ Ended:_____

Anti-depressants: Amitriptyline, Nortryptiline, Effexor, Paxil, Prozac
Date Started: _____ Ended:_____

Anti-epileptics: Gabapentin, Lyrica, Topiramate, Valproic Acid, Depakote
Date Started: _____ Ended:_____

Beta Blockers: Atenolol, Metoprolol/Lopressor, Propanolol/Inderal, Timolol
Date Started: _____ Ended:_____

Calcium Channel Blockers: Diltiazem, Nifedipine, Verapamil
Date Started: _____ Ended:_____

Others: Excedrin, Fioricet, Fiorinal, Stadol, Midrin, Cafergot, Butalbital
Date Started: _____ Ended:_____

Muscle Relaxers
Date Started: _____ Ended:_____

NSAIDs: Advil, Ibuprofen, Aleve
Date Started: _____ Ended:_____

Injections: Botox injections, Aimovig injections
Last Treatment Date:_____

Others*:* **_____**