PACIFIC
Sports and Spine

Dr. Gregory Phillips ☐ Devon Parks, PA-C ☐
Dr. Gregory Moore ☐ Dana Rubin PA-C ☐

Today's Date: _____

Name: _____ Date of Birth: _____ Social Security #: _____

Sex: ☐ M ☐ F Height_____ Weight_____

Language:_____ Ethnicity: ☐ White ☐ American Indian ☐ African American ☐ Asian ☐ Hispanic/Latino

How were you referred to us?
☐ Physician ☐ Patient/Friend ☐ Workers Comp ☐ Insurance ☐ Internet ☐ TV/Radio
☐ Self ☐ Other:_____

Primary Care Physician: _____ Pharmacy Name/Location: _____

Referring Physician: _____ Specialty: _____

History of Present Illness:

What is your main pain complaint? _____

Which best describes the quality of your current pain complaint?
☐ Sharp ☐ Burning ☐ Throbbing ☐ Shooting ☐ Aching ☐ Stabbing ☐ Dull

☐ Other: _____

Have you missed work because of this pain? ☐Yes ☐No

Pain severity Please rate your pain by circling the one number that describes your average pain:

What is your average daily pain level? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

What is your pain level at its worst? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

What is your pain level at its best? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

How often do you have pain? ☐ Constant ☐ Occasional (several times per week) ☐ Intermittent (several times per day)
☐ Rarely (several times per month)

How long have you had this pain? (weeks/months/years)? _____

How did your current main pain complaint begin? Please give details and dates: _____

_____

Was your pain the result of any of the following? ☐ Work related injury ☐ Auto Accident

☐ Fall or other trauma ☐ Following Surgery ☐ Following Illness ☐ Pain just began

☐ Other: _____

How do the following activities affect your pain?

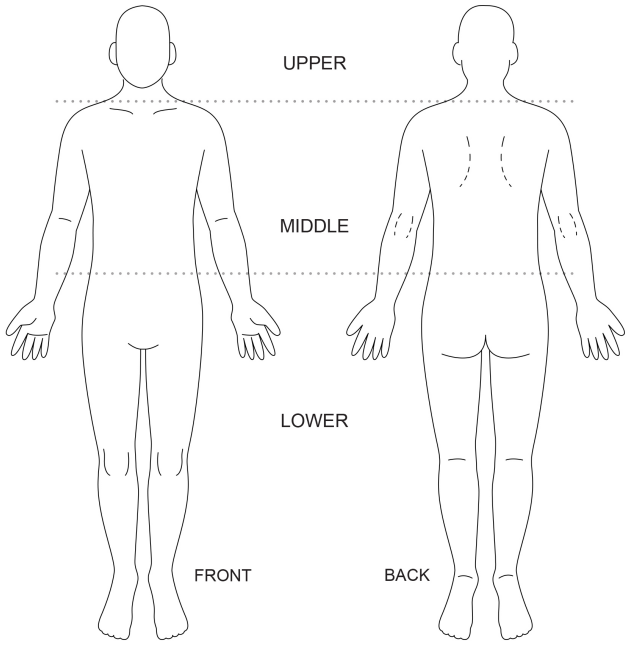
	Aggravates Pain	Relieves Pain	Neither
Exercise	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Bending forward	☐	☐	☐
Bending backward	☐	☐	☐
Lying down	☐	☐	☐
Sleeping	☐	☐	☐
Walking	☐	☐	☐
Sneezing	☐	☐	☐
Coughing	☐	☐	☐
Driving	☐	☐	☐
Other_____	☐	☐	☐

Is your pain associated with other symptoms? ☐ No ☐ Sleep Loss ☐ Sexual Dysfunction
☐ Numbness, where _____ ☐ Muscle weakness, where _____ ☐ Other: _____

Since your present pain began, have you experienced the following?
☐ Urinary incontinence/dysfunction ☐ Bowel incontinence/dysfunction ☐ Neither

Please list your goals for treatment (Hobbies, return to work, etc…)
_____
_____
_____
_____

Please circle the area of pain you are having:



Please list all MEDICATIONS you are currently taking. Include prescription drugs, over the counter (OTC), and herbal supplements:

Medication & Dose:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Taking Aspirin? If so _____mg Last taken: _____ Blood thinner _____ Last taken: _____

Maximum number of pain pills you take each day? _____

Please list all **PREVIOUS PAIN MEDICATIONS** you have tried and are no longer taking: (Examples)

☐ Tramadol ☐ Cymbalta ☐ Neurontin ☐ Lyrica ☐ Nortriptyline/Amitriptyline ☐ Ibuprofen/Aleve

☐ Opiates (Ex. Morphine, Oxycodone, Fentanyl, etc…): _____

☐ Other: _____

Do you have any known **MEDICATION ALLERGIES**? If so, please list:

_____

Other: _____

REACTIONS: _____

_____

Previous Work-Up:

Have you had any of the following tests in relation to your pain, and if so what body part, when, and where was it performed?

☐ X-Ray ☐ CT ☐ MRI ☐ Ultrasound ☐ Myelogram ☐ Bone Scan

☐ Dexa Scan ☐ EMG ☐ Functional Capacity Evaluation (FCE) ☐ Other: _____

Previous Therapies:

Have you had any of the following in relation to your pain, and if so when and where?

☐ PT (Physical Therapy)	☐ OT (Occupational Therapy)	☐ TENS	☐ Epidural Steroid Inj
☐ Nerve Blocks	☐ Weight loss/Nutrition	☐ Discogram	☐ Spinal Cord Stimulator
☐ Intrathecal Pain Pump	☐ Vertebroplasty	☐ Acupuncture	☐ Chiropractic
☐ Joint Injections	☐ Bracing	☐ Orthotics	☐ Biofeedback
☐ SI Belt	☐ Psychology/Psychiatry	☐ Pilates	☐ Yoga
☐ Naturopathy/Homeopathy	☐ Other: _____		

Past Medical History (please circle if you have had any of the following):

Anemia	COPD	Hemorrhoids	Parkinson's
Aneurysm	Dementia/Alzheimer's	Hepatitis/liver disease	Pelvic pain
Anorexia/bulimia	Dental problems	Hernia	Pulmonary embolism
Anxiety	Depression	High blood pressure	PVD
Arthritis	Diabetes	High cholesterol	Restless legs
Asthma	Diverticulosis/diverticulitis	HIV or AIDS	Rheumatism
Back problems	DVT	Hypertension	Seizures/epilepsy
Bipolar disorder	Emphysema	Kidney disease	Sleep apnea
Bleeding disorder	Endometriosis	Lung disease	Sleep disorder
Blood clots	Environmental allergies	Multiple sclerosis	Stroke/TIA
Bowel/bladder issues	Fibromyalgia	Muscle/joint/bone issues	Testicular/prostate cancer
BPH	GERD	Neck problems	Thyroid problems
Bronchitis	Gout	Neuropathy	Tremor
CAD/heart disease	Head trauma/injury	Obesity	Tuberculosis
Cancer	Headaches/migraines	Osteoporosis	Ulcers
Chronic fatigue syndrome	Heart arrhythmia	Ovarian cysts	Other _____

Surgical History (circle if you have had any of the following and write date):

_____ AAA repair	_____ Elbow surgery	_____ Mitral valve surgery
_____ AICD	_____ ENT surgery	_____ Neck surgery
_____ Ankle/foot surgery	_____ Eye surgery	_____ Neurosurgery
_____ Aortic valve surgery	_____ Fracture surgery	_____ Oncology surgery
_____ Appendectomy	_____ Gastric bypass	_____ Pacemaker
_____ Arm surgery	_____ Gastrointestinal surgery	_____ Plastic surgery
_____ Atrial septal defect repair	_____ General surgery	_____ Prostatectomy
_____ Back surgery	_____ Genitourinary surgery	_____ Renal surgery
_____ Bladder surgery	_____ Heart surgery	_____ Shoulder surgery
_____ Brain surgery	_____ HEENT surgery	_____ Skin cancer excision
_____ Breast surgery	_____ Hemorrhoidectomy	_____ Spinal surgery
_____ CABG	_____ Hernia repair	_____ Stent
_____ Caesarean section	_____ Hip replacement	_____ Thoracic surgery
_____ Cardiac catheterization	_____ Hip surgery	_____ Thyroid surgery
_____ Cardioversion	_____ Hysterectomy	_____ Tonsillectomy
_____ Carpal tunnel surgery	_____ Interventional radiology	_____ Transplant
_____ Cataract surgery	_____ Joint replacement	_____ Tricuspid valve surgery
_____ Cervical spine surgery	_____ Knee replacement	_____ Tubal ligation
_____ Cholecystectomy	_____ Knee surgery	_____ Vascular surgery
_____ Colectomy	_____ Leg surgery	_____ Wisdom teeth extraction
_____ Congenital heart defect surgery	_____ Lower extremity amputation	_____ Wrist/hand surgery
_____ Coronary artery intervention	_____ Lumbar spine surgery	Other _____
_____ Craniotomy	_____ Lumpectomy	Other _____
_____ Dilatation & curettage	_____ Lung surgery	Other _____

Review of Systems: Mark all that apply to your problems/symptoms

☐ Recurrent fevers, chills, sweats	☐ Vomiting blood	☐ Numbness/tingling sensation
☐ Recent weight changes	☐ Frequent diarrhea	☐ Seizures
☐ Loss/changes of vision	☐ Heat or cold intolerance	☐ Headaches
☐ Chronic sinus problems	☐ Severe heart burn	☐ Enlarged lymph nodes
☐ Voice changes	☐ Lack of bladder control	☐ Depression
☐ Chest pain	☐ Excessive urination	☐ Nervousness
☐ Irregular heart rhythm	☐ Burning with urination	☐ Extreme fatigue
☐ Chronic cough	☐ Constipation	☐ Excessive thirst
☐ Shortness of breath	☐ Change in sexual function	☐ Easy bruising
☐ Coughing up blood	☐ Weakness	☐ Frequent bleeding
☐ Abdominal pain	☐ Difficulty walking	☐ Environmental allergies
☐ Abnormal mole	☐ Rash	

Have you ever had mental health treatment? ☐ Yes ☐ No If yes, please describe: _____

Have you ever been treated for cancer? ☐ Yes ☐ No If yes, what type? _____

Have you or any family members had any problems with anesthesia? ☐ No ☐ Yes

Social History:

Current Occupation:_____ Employer: _____

Present employment status: ☐ Fulltime ☐ Part time ☐ Retired ☐ Disability ☐ Worker's Comp

How would you describe your work? ☐ Sedentary (lift less than 10 lbs) ☐ Light (lift 10-25 lbs)
☐ Light to medium (lift 25-50 lbs) ☐ Medium (lift 50-75 lbs)
☐ Medium to heavy (lift 75-100 lbs) ☐ Heavy (lift more than 100 lbs)

Do you have physical work restrictions? ☐ Yes ☐ No ☐ N/A

If not currently working, what was your last job? _____

How long have you been out of work? _____

Are you: ☐Right-handed ☐Left-handed ☐ Ambidextrous

What is your highest education level? ☐ High school ☐ Vocational degree ☐ College ☐ Advanced Degree
☐ Other: _____

Marital Status: ☐ Single ☐ Married-Name of Spouse: _____ ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No If yes, how many? _____ What are their ages? ___ ___ ___ ___ ___ ___ ___

Exercise level: ☐occasional ☐moderate ☐heavy

Do you use caffeine: ☐occasional ☐moderate ☐heavy

Do you use tobacco? ☐ Never ☐ Yes _____ packs per day ☐ Former User, quit: _____

Do you use alcohol? ☐ Never ☐ Regularly ☐ Rarely

Have you used recreational drugs in the last 5 years? ☐ Yes ☐ No If yes, please list: _____

Do you have a history of Alcoholism, drug abuse, or addiction? ☐ Yes ☐ No

What is your current living situation? ☐ Alone ☐ with _____

What are your living accommodations? ☐ Apartment ☐ House ☐ Assisted Living
☐ Nursing Home ☐ Homeless ☐ Other: _____

Do you have an application pending or do you intend to apply for workers compensation or disability? ☐ Yes ☐ No

Do you have a pending lawsuit for your pain or injury? ☐ Yes ☐ No Name of attorney: _____

Family History:

Are you adopted? ☐ **Yes** ☐ **No**

Please indicate the age and status of the following family members (if deceased, please indicate age at time of death and cause of death):

	Alive	Deceased
Age of Father	_____	_____
Age of Mother	_____	_____
Ages of Brothers	_____	_____
Ages of Sisters	_____	_____
Ages of Children	_____	_____

Using the key below, please indicate if any of your immediate relatives have any of the following:

F= Father M= Mother B= Brother S= Sister MGF= Maternal grandfather MGM= Maternal grandmother PGF= Paternal grandfather PGM= Paternal grandmother

_____ Addiction	_____ History of back problem	_____ Brain tumor
_____ Alzheimer's Disease	_____ History of musculoskeletal issues	_____ Osteoarthritis
_____ Blood coagulation disorder	_____ Hypertensive disorder	_____ Osteoporosis
_____ Stroke	_____ Malignant hypertension	_____ Rheumatoid Arthritis
_____ Diabetes	_____ Cancer	_____ Seizure
_____ Disorder of neck	_____ Migraine	_____ Tuberculosis
_____ Heart disease	_____ Multiple sclerosis	_____ Other: _____

I attest that information provided here is true and correct to the best of my knowledge.

Signature: _____ Date: _____