SPACE CITY PAIN SPECIALISTS

History and Physical

PLEASE COMPLETE THIS FORM BEFORE YOUR VISIT. USE BLUE/BLACK INK ONLY

NAME: _____ AGE: _____ SEX: ❑ M ❑ F

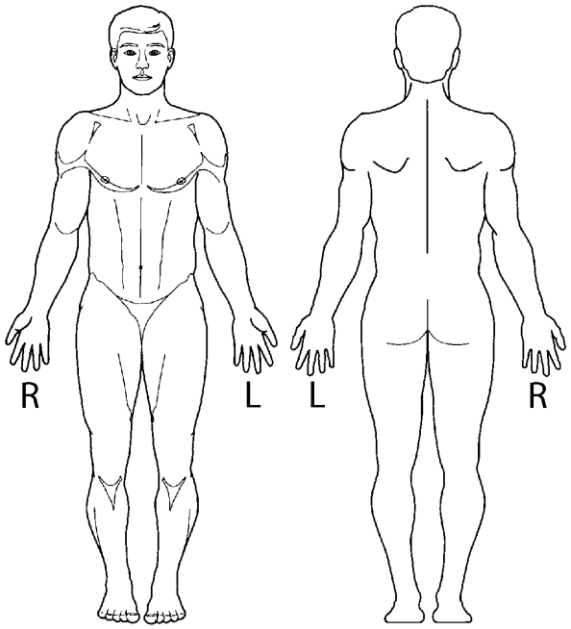
I. Chief Complaint (CC)

Referred by (Doctor):_____

In your own words, why are you here?

On the diagram, **shade** the area(s) where you *feel* pain.

Mark the areas which hurt the *most* with an "**X**".



II. Check the word(s) which describes your pain.

❑ Burning	❑ Sharp	❑ Pins & Needles
❑ Sensitive	❑ Aching	❑ Electric
❑ Throbbing	❑ Shooting	❑ Stabbing

III. When does your pain occur?

❑ Constantly	❑ Occasionally
❑ With stress	❑ At the same time each day
❑ Without warning	❑ When I move a certain way

IV. History of Present Illness (HPI)

When did the pain begin?

What do you feel caused the pain?

Do you have:

Numbness (location) _____

Tingling (location) _____

Weakness (location) _____

Pain Scale:

My current pain is ..... ***No pain*** - 0	1	2	3	4	5	6	7	8	9	10 - ***Extreme pain***
During the **past week**, the **best** my pain has been is ..... ***No pain*** - 0	1	2	3	4	5	6	7	8	9	10 - ***Extreme pain***
During the **past week**, the **worst** my pain has been is ..... ***No pain*** - 0	1	2	3	4	5	6	7	8	9	10 - ***Extreme pain***
During the **past week**, my **average** pain has been ..... ***No pain*** - 0	1	2	3	4	5	6	7	8	9	10 - ***Extreme pain***
During the **past 3 months**, my **average** pain has been ..... ***No pain*** - 0	1	2	3	4	5	6	7	8	9	10 - ***Extreme pain***

What makes your pain worse?
(Please CHECK)

❑ coughing ❑ sneezing ❑ straining
❑ walking ❑ sitting ❑ standing
❑ heat ❑ cold ❑ lying down
❑ bending forward ❑ bending backward ❑ other:

What makes your pain better?
(Please CHECK)

❑ walking ❑ sitting
❑ standing ❑ lying down
❑ heat ❑ cold
❑ bending forward ❑ bending backward ❑ other:

Previous Treatments (mark the box if you have tried):

❑ Chiropractor ❑ Physical therapy ❑ Acupuncture

❑ Massage ❑ Injections or procedures (please list type of injection or procedure below)

Procedure Month / Year Body Location Physician

_____

_____

Medicines previously tried for pain (list each medicine, include over the counter medications):

_____

V. Past History (Medical, Surgical, Family, Social, Hospitalizations)

Past Medical History: Please CHECK those that apply TO YOU (not your family) and describe if indicated.

❑ Peripheral Neuropathy	❑ Easy Bruising/Bleeding	❑ Heart Attacks	❑ Heart Failure	❑ High Blood Pressure
❑ Poor Circulation	❑ Irregular Heartbeat	❑ Arthritis	❑ Thyroid Disease	❑ Diabetes
❑ Reflux / GERD	❑ Overweight	❑ Depression	❑ Sleep Apnea	❑ Osteoporosis
❑ Anxiety	❑ Bipolar Disorder	❑ Other:		
❑ Stroke(s) SIDE: ❑ Rt ❑ Lt	❑ Kidney Disease TYPE:	❑ Lung Disease TYPE:	❑ Cancer TYPE:	

Past Surgical / Hospital History

Operation or Illness	Month / Year	Operation or Illness	Month / Year
1)		3)	
2)		4)	

Are you on a blood thinner? ❑ Yes ❑ No If YES, which one: _____

Allergies: Please list any drug, food, contact or environmental allergies and reactions:

SPACE CITY PAIN SPECIALISTS

VI. Review of Systems (ROS)

Please CHECK all CURRENT conditions you have. CIRCLE "*Negative*" if you have no complaints.

General Questions	Muscles, Bones & Joints	Digestive System	Brain & Nerves
Negative	*Negative*	*Negative*	*Negative*
❑ Weight loss	❑ Neck pain	❑ Diarrhea	❑ Headaches
❑ Weight gain	❑ Back pain	❑ Constipation	❑ Head injuries
❑ Fevers	❑ Gout	❑ Nausea	❑ Fainting spells, dizziness
❑ Change in sleep patterns	❑ Tendonitis	❑ Vomiting	❑ Blackouts or fainting
❑ Change in activity level	❑ Swollen areas	❑ Heartburn	❑ Memory Loss
Psychological	❑ Joint swelling	❑ Abdominal pain	❑ Tremors
Negative	❑ Morning stiffness	❑ Problems swallowing	❑ Paralysis
❑ Depression	❑ Muscle aches	❑ Vomiting blood	**Ears, Eyes, Nose & Throat**
❑ Anxiety and worry	❑ Rheumatism	❑ Black tarry stools	*Negative*
❑ Emotional outburst	❑ Joint aches	❑ Bloody bowel movements	❑ Glaucoma
❑ Difficulty thinking	❑ Bursitis	**Kidneys & Bladder**	❑ Nasal Polyps
❑ Racing Thoughts	**Heart, Blood & Circulation**	*Negative*	❑ Allergy
❑ Difficulty falling asleep	*Negative*	❑ Bloody urine	❑ Hoarseness
❑ Hearing voices	❑ Chest pain	❑ Dribbling after urination	❑ Double vision
❑ Repetitive Habits	❑ Leg cramps / pain	❑ Painful urination	❑ Eye problems
Skin	❑ Ankle swelling	❑ Poor bladder control	❑ Hearing Loss
Negative	❑ Shortness of breath at rest	❑ Urinating frequently	❑ Ear discharge / pain
❑ Rashes	❑ Cold hands or feet	❑ Difficult starting urine	❑ Ringing in your ears
❑ Psoriasis	❑ Heart defects	❑ Weak flow	**Lungs & Breathing**
❑ Dry Skin	❑ Heart murmurs		*Negative*
❑ Lumps	❑ Heart palpitations		❑ Wheezing
❑ Increased nail growth	❑ Varicose veins		❑ Prolonged cough
❑ Increased hair growth	❑ Blood clots in legs / lungs		❑ Coughing up blood
❑ Skin color changes	❑ Anemia		❑ Emphysema
❑ Shiny skin			❑ Shortness of breath
			❑ Lung infections

Family History: Please check any FAMILY illnesses. Only include your parents and siblings (i.e. sisters/brothers)

Illness	Relationship	Illness	Relationship	Illness	Relationship
❑ Stroke	❑Mom ❑Dad ❑Sis ❑Bro	❑ Panic Attacks	❑Mom ❑Dad ❑Sis ❑Bro	❑ Lung disease	❑Mom ❑Dad ❑Sis ❑Bro
❑ Diabetes	❑Mom ❑Dad ❑Sis ❑Bro	❑ Heart disease	❑Mom ❑Dad ❑Sis ❑Bro	❑ High blood pressure	❑Mom ❑Dad ❑Sis ❑Bro
❑ Obesity	❑Mom ❑Dad ❑Sis ❑Bro	❑ Back problems	❑Mom ❑Dad ❑Sis ❑Bro	❑ Depression	❑Mom ❑Dad ❑Sis ❑Bro
❑ Cancer	❑Mom ❑Dad ❑Sis ❑Bro	❑ Kidney disease	❑Mom ❑Dad ❑Sis ❑Bro	❑ Bipolar / OCD	❑Mom ❑Dad ❑Sis ❑Bro
Other:					

Social History:

WHERE DO YOU WORK?		❑ Full time ❑ Part time ❑ Unemployed ❑ Disabled ❑ Retired
Do you exercise regularly?	❑ YES ❑ NO	What type? How often?
Do you smoke?	❑ YES ❑ NO	If YES how often? cigs/day packs/wk
Do you drink alcohol?	❑ YES ❑ NO	If yes, how often? drinks/day drinks/wk
Has your pain ever stopped you from working?	❑ YES ❑ NO	If YES, please explain:
Are you suing anyone about your pain problem?	❑ YES ❑ NO	If YES, please explain:

I acknowledge that I have received, read, and understood Space City Pain Specialists *Consents, Agreements, and Acknowledgements* including the *General Waiver of Liability, Consent for Treatment, Urine Testing Agreement,* and *Notice of Privacy Practices.*

Signature: _____ Date: _____

For physician use ONLY:

Assessment:

Minor prob:	Estab prob-stable:	Estab prob-worse:	New prob-stable:	New prob-need w/u:	**TOTAL**
____x 1 =____ (max 2)	____x 1 = ____	____x 2 = ____	____x 3 =____ (max 1)	____x 4 = ____	
				❑ Level 3 = 2 ❑ Level 4 = 3	

Data Interpretation:

❑ Review / order labs (1)	❑ Review / order X-rays (1)	❑ Review / order med tests (1)	❑ Discuss results w/ testing Dr. (1)
❑ Order old records / add Hx (1)	❑ Review / summarize old records / add Hx (2)	❑ View X-ray, tracing or slide, prev interp by other Dr. (2)	**TOTAL:** **❑ Level 3 = 2** **❑ Level 4 = 3**

Plan:

❑ **Level 3** (need 1)	❑ 2+ minor problems	❑ 1 chron prob stable	❑ Acute prob-uncomplicated	❑ OTC Rx (list)	❑ PT / OT	❑ Minor surg (no risk)
❑ **Level 4** (need 1)	❑ 1+ chronic prob-mild incrs	❑ 2+ chronic prob-stable	❑ Acute prob-systemic(pneum)	❑ New prob-uncertain Prog	❑ Rx drugs (list)	❑ Minor surg (w/ risk factors)

History Level (3 of 3 required)**:** _____
❑ All historical information reviewed with patient by Physician. **Exam Level:** _____
Decision Level (2 of 3 required)**:** _____
Final Level: _____

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information. To the person(s) or entity listed below.

Space City Pain Specialists, LLP
17448 Hwy 3, Suite 136
Webster, TX 77598
Phone: 281.338.4443
Fax: 281.338.8821

The reasons or purpose for this release of information are as follows:
_____*Continuity of Care*_____

I understand that you will provide this information within 15 days from *receipt* of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Examiners.

In addition to the authorization of release of information to my healthcare provider, I also authorize the release of my Protected Health Information (PHI) to any one of the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Limitations on the information you may release subject to this release form are as follows:
_____
_____
_____

Patient Name:

_____

Representative Name:

_____

Patient/Parent/Guardian/Legal Representative Signature: **Date:**

_____ _____