Scott Integrated Pain Management, LLC

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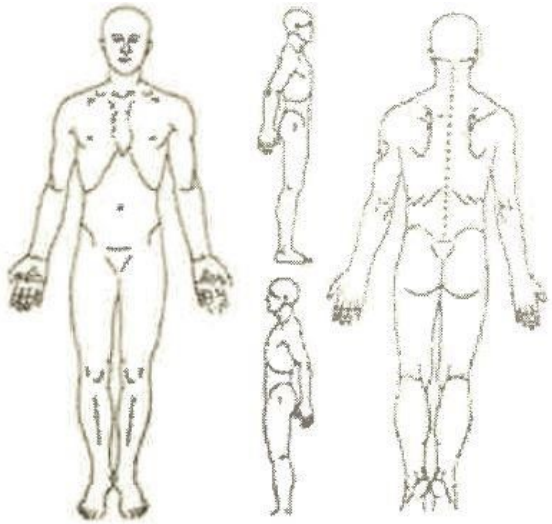
Health History		
Who referred you to us?	Date:	
History of your symptoms:		
When did it start?		☐ Gradual ☐ Sudden
Is your pain due to: ☐ Motor Vehicle Accident ☐ Work Injury		Cell phone #:

Please describe how your injury/pain occurred:

Where is your pain:



How would you characterize your pain: ☐ Dull ☐ Knife like ☐ Achy ☐ Cramping ☐ Burning ☐ Sharp ☐ Number ☐ Other:

How many hours do you sleep at night:	Have you felt depressed or frustrated due to your pain: ☐ Yes ☐ No

Previous Treatments: Have you had any of the following:

☐ Epidural/s Date(s): _____ Physician(s): _____

☐ Nerve block(s) Date(s): _____ Physician(s): _____

☐ Surgery/ies Date(s): _____ Physician(s): _____

☐ Physical Therapy Date(s): _____ Physician(s): _____

☐ Chiropractic Date(s): _____ Physician(s): _____

Social History:

What is your current work situation: ☐ Retired ☐ Working ☐ Disability ☐ On leave ☐ Other:

What is your home situation: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Tobacco Use: ☐ I do not smoke ☐ I do smoke _____ pack(s) per day

Alcohol Use: ☐ I do not drink ☐ I do drink _____drink(s) per day

Illegal Drug Use: ☐ I do not us any ☐ I currently use the following:

Family History:

Please list any conditions your parents or siblings may have:

Past Medical History:

Please list any medical issues you are being treated for or take prescription medication for:

Medications:

Please list all your prescription medications:

Allergies:

Other Symptoms:

Do you experience any of these other symptoms:

☐ Fevers ☐ Chills ☐ Unusual Bruises ☐ Weight Loss ☐ Night Sweats ☐ Rashes ☐ Recent Infections ☐ Bladder/Bowel Incontinence