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California Advanced Pain Institute
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Treatment History

Please list all of the health care providers you have consulted regarding your pain and their treatment plan:

Orthopedic/Spine Surgeon _____
Neurologist _____
Rheumatologist _____
Pain Management _____
Primary Care _____
Physical Therapist _____
Acupuncturist _____
Occupational Medicine _____
Chiropractors _____
Alternative Medicine _____
Rehabilitation Medicine _____
Other _____

Please mark the medications that you have tried for your pain in the past and their effectiveness.(0 no help, 10 very helpful)

Name of medication	**Effectiveness (0 - 10)**
( ) Tylenol	
( ) NSAID's: Motrin / Advil / Ibuprofen, etc.	
( ) Opioids: Vicodin / Norco / Oxycodone, etc.	
( ) Oral Steroids / Medrol dose pack	
( ) Amitriptylene (Elavil), Nortriptylene (Pamelor), etc.	
( ) Neurontin / Topamax / Tegretol, etc.	
( ) Others	

Other General Medications

Name:	Dosage	Frequency

Past Medical History

Name of Illness:	Duration

Allergies: _____

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Treatment History (con't)

Past Surgical History

Name of Surgery	Date

Family History *(Please list the members of your family with chronic long term conditions, i.e., Diabetes, etc.)*

Social History

Occupation: Marital Status:
Education: On Disability: ( ) Yes ( )No
Use of Tobacco (type and how long) _____
Use of Alcohol (type and how long) _____
Use of Recreational Drugs (type and how long) _____

Review of Systems

Constitutional ( ) Fever ( ) Weight Loss ( ) Fatigue

Eyes ( ) Blurred Vision ( ) Redness ( ) Double Vision ( ) Vision Loss

Ear/Nose/Throat ( ) Trouble hearing ( ) Ringing in the Ear ( ) Loss of Balance ( ) Dizziness/Vertigo
( ) Ear Discharge

Cardiovascular ( ) Chest Pain/Angina ( ) Irregular Heart Beat ( ) Limb Swelling ( ) Fainting

Respiratory ( ) Trouble Breathing ( ) Chronic cough ( ) Coughing Blood

Gastrointestinal ( ) Indigestion ( ) Nausea ( ) Vomiting ( ) Diarrhea ( )Heart burn
( ) Constipation ( ) Bloody stools

Genitourinary ( ) Incontinence ( ) Pain on Urination ( ) Blood in Urine

Musuloskeletal ( ) Muscle Pain ( ) Muscle Cramp ( ) Neck Pain
( ) Back Pain ( ) Joint Swelling ( ) Joint Pain ( ) Stiffness

Skin & Breast ( ) Numbness ( ) Hair Loss ( ) Discoloration

Neurologic ( ) Headache ( ) Weakness ( ) Tremors
( ) Trouble with memory/concentration ( ) Blackouts ( ) Seizures

Psychiatric ( ) Hallucinations ( ) Feeling Down ( ) Trouble Sleeping
( ) Suicidal Thoughts ( ) Inappropriate Crying/Laughing

Hematologic/Lymphatic ( ) Abnormal Bleeding ( ) Anemia ( ) Lumps Swelling

Allergic/Immunologic ( ) Rash ( ) Joint Pain ( ) Dry Eyes/Mouth

Endocrinologic ( ) Excessive Thirst ( ) Heat/Cold Intolerance ( ) Excessive Urination

Signature: Patient/Guardian _____ **Date:** _____