Weill Cornell Medical College
Interventional Pain and Sports Medicine

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TODAY'S DATE: _____

FULL NAME: _____ DATE OF BIRTH: _____

REFERRED BY: __Dr._____ DOCTOR'S PHONE #:_____

WHAT BRINGS YOU IN TODAY? _____

DURATION OF SYMPTOMS: _____ HOW DID IT BEGIN? _____

Please complete the following:

RATE YOUR PAIN ON A SCALE OF 0 TO 10

(0 = no pain 10 = extreme pain)

1. Right Now: 0 1 2 3 4 5 6 7 8 9 10

2. At Best: 0 1 2 3 4 5 6 7 8 9 10

3. At Worst: 0 1 2 3 4 5 6 7 8 9 10

4. What does the pain feel like (check all that applies)?

[ ] Sore [ ] Aching [ ] Burning

[ ] Sharp [ ] Dull [ ] Tender

[ ] Stabbing [ ] Tingling [ ] Cramping

[ ] Shooting [ ] Pulling [ ] Radiating

5. What makes it better (check all that applies)?

[ ] Heat [ ] Cold [ ] Bending Forward

[ ] Sitting [ ] Standing [ ] Bending Back

[ ] Walking [ ] Twisting [ ] Lying Down

[ ] Coughing [ ] Sneezing [ ] Weather Change

[ ] Sexual Intercourse [ ] Nothing

6. What makes it worse (check all that applies)?

[ ] Heat [ ] Cold [ ] Bending Forward

[ ] Sitting [ ] Standing [ ] Bending Back

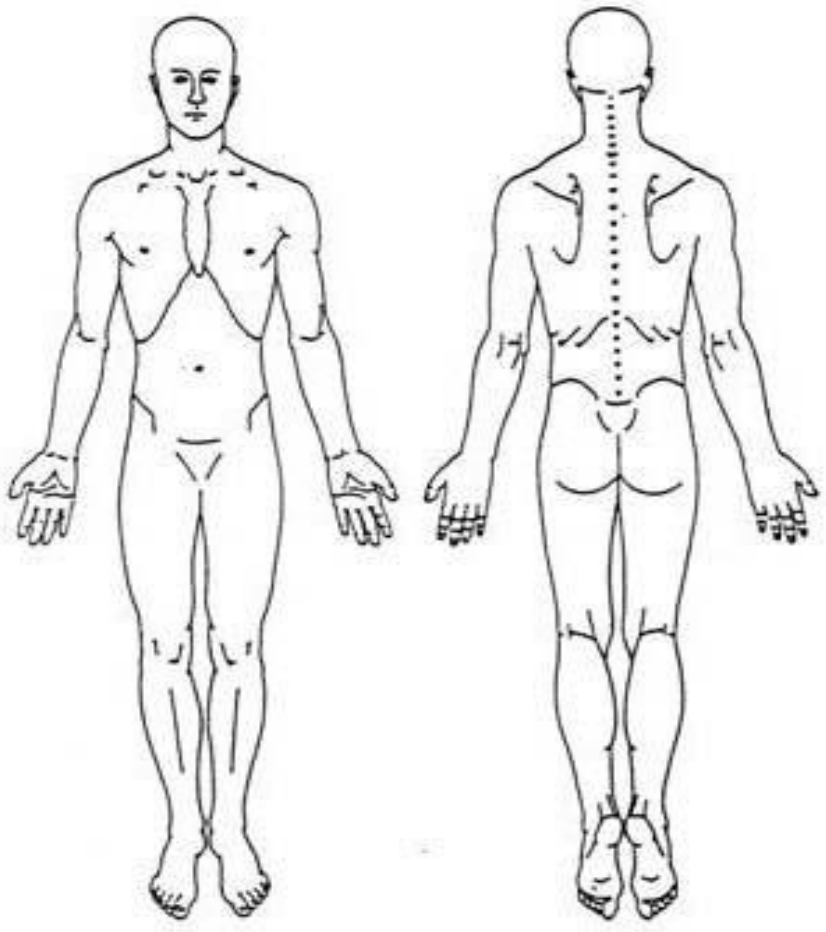
[ ] Walking [ ] Twisting [ ] Lying Down

[ ] Coughing [ ] Sneezing [ ] Weather Change

[ ] Sexual Intercourse [ ] Nothing

Mark the areas of pain on the figure below

R *L* *L* *R*



7. DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

Weight Change	Fever/Chills	Stomach Problems
Joint pain/ Swelling	Bowel/Bladder Incontinence	Morning Stiffness
Weakness	Numbness or Tingling	Skin Problems
Depression/Anxiety	Sleep Problems	Headaches
Rash	Other _____	

8. HAVE YOU HAD ANY OF THE FOLLOWING TESTS OR TREATMENTS FOR YOUR CURRENT PROBLEM?

X-RAYS	_____	**EMG (Nerve Test)**	_____	**CT SCAN**	_____
BONE SCAN	_____	**MRI SCAN**	_____	**INJECTION**	_____
SURGERY	_____	**PHYSICAL THERAPY**	_____	**MEDICATIONS**	_____

List names of medications for current problem: _____

9. MEDICAL HISTORY

***PAST MEDICAL PROBLEMS**:*

_____

PAST SURGERIES:

_____

CURRENT MEDICATIONS:

_____

MEDICATION ALLERGIES:

_____

DO YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING? Contrast/IV Dye Latex

10. DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Family Member	Alive	Arthritis	Cancer	Heart Disease	Diabetes	Other
Father	Y N					
Mother	Y N					
	Y N					

11. SOCIAL HISTORY

Tobacco: Never Smoker Former Smoker Smoker

Alcohol use: YES or NO if so, how many drinks in 1 week: _____

Drug Use YES or NO