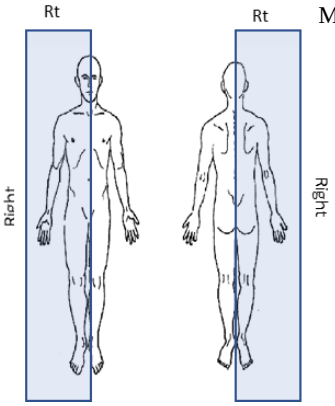
PAIN INSTACARE INITIAL EVALUATION FORM

Name:		**Date of Visit:**	**Date of Injury:** **State of Injury: NJ / PA / DE / other -**	**Date of Birth:** **Age:** **Sex: M / F**
Insurance:		**Referred by:** **Chiro / Ortho/ PCP / self / friend**	**Attorney:**	**PCP:**
MR #	**GIP** **PIC**	**Requesting Company:** **D&D, ISG, MCN**	**Type of Injury:** **MVA / WC / Slip & Fall**	**Is this IME: Yes / No** **Start:** **End:**

CHIEF COMPLAINTS: Headaches Neck Pain Upper Extremity Pain (L / R) Upper Back Pain Chest Pain Facial Pain
(Circle all that applies) Low back Pain Lower Extremity Pain (L / R) Foot Pain L/R) Pelvic Pain Buttock pain (L/R)
Whole body pain Hip Pain (L / R) Shoulder Pain (L/R) Knee pain (L/R) Elbow pain (L/R) Wrist pain(L/R)
Multiple joints pain other _____



Pain characteristics are:

Intensity: _____/_10 (Today) **Duration**: (How Long ago it started)
_____

Quality: Dull / Sharp / Shooting / Burning / Throbbing / Stabbing / Aching / knife like / Other _____

Aggravating factors: □ Physical activity □ Bending □ Twisting □ Lifting □ Walking Sitting □ Standing □

Relieving factors: □ laying down □ Physical Activity □ Medications

HISTORY OF PRESENT ILLNESS: How and when did your pain start? (Please describe what happened)

_____

_____

_____

Is your pain related to an Injury? If yes (circle) **AUTO / Pedestrian MVA / Work Related / Slip and Fall** / Animal Bite

Date of Injury _____ **State of Injury**: NJ / PA/ DE / Other _____ **IMPACT**: Rear Ended / Front ended / Side Impact

You were Driver / Passenger / Restrained (seat belt) / unrestrained / Lost consciousness / Airbags deployed / Taken to Emergency by Ambulance / Patient drove to ER / Seek medical care first: _____

Is Claim still open: Yes/ No / LOP **Were you working at the time of accident**: Yes / No Are you working Now: Yes / No

PREVIOUS INJURIES / PREEXISTING CONDITIONS to account for your pain. Pls mention any type of injury

Previous MVA : Year _____ Resolved / Unresolved Other injury: _____ Year: _____ Outcome: _____

Previous Medical Conditions: _____

PREVIOUS TESTS PERFORMED: □ X-Rays □ Bone Scan □ CAT Scan (CT) □ MRI □Myelogram □EMG □ Other

1. MRI (which part) Cervical / Thoracic / Lumbar _____ 2. EMG UE / LE _____

3. _____ 4. _____

PREVIOUS TREATMENTS: Physical Therapy (when) _____Medications _ _____

Chiropractic Care _____ / **Acupuncture** / **Pain Mx**: _____Injections (Epidural / Facet Block / Sacroiliac / Selective Nerve Root Block / Discogram _____**Ortho /Surgery** _____**PCP**_____

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ALLERGIES: □ No known Drug Allergies / Allergy to IV Dye / Iodine / Shell fish / sea food / **Medications** _____

CURRENT MEDICATIONS: List your current medications / See attached list

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

*Are you taking blood thinners? □ Aspirin □ Coumadin □ Plavix Pradaxa

PAST MEDICAL HISTORY (Please Check all that applies) □

□Diabetes / □Hypothyroid / □Hyperthyroid / □Heart Disease / □Hypertension / □Stroke □/ Lungs disease / HIV / AIDS
□/Hepatitis □Depression / □Anxiety / □Bipolar /□ Psychosis /□ Kidney Disease □ Cancer _____
□Neck Pain / □Mid-back pain / □Low back pain / □Fibromyalgia / □Arthritis / □Rheumatoid Arthritis / □Multiple sclerosis /
□Shingles **Last Menstrual Period** (Females) _____ □ **Are you Pregnant** (Females) No / Yes _____

PAST SURGICAL HISTORY:

□Spine Surgery □Cervical / □Thoracic / □Lumbar _____Do you have : □ Spinal Cord Stimulator / □ Intrathecal Pump
□Heart Surgery □Lung Surgery □ Appendectomy □ Hysterectomy □ Gall Bladder □Tonsillectomy
□Joint Replacement (□ Hip / □Knee / □Shoulder Right / Left) _____ Other _____

SOCIAL HISTORY: (Please mention and mark yes or no and how much)

Marital Status: □Married / □Single / □Divorced / □Widowed **Smoke** (yes /no) _PPD **Alcohol** (yes/No) ____ Illicit Drugs (yes/no)
Occasional / Social **Smoke Marijuana / weed**
Occupation: Working as _____Not working / Disabled (due to) _____

FUNCTIONAL HISTORY: Are you able to do activities of daily living and walking?

Activity of Daily Living □ Independent □ Dependent _____On person / Device : _____
Ambulation □ Independent □ Dependent with Person / Device: cane / walker / crutches _____

FAMILY HISTORY: Please tell us age, disease suffering, alive or diseased

Father: □ Alive / □ Deceased / _____ Mother: □ Alive / □ Deceased _____
Cause of death or medical conditions **Cause of death or medical conditions.**

REVIEW OF SYSTEM: ***All the systems were reviewed and Positive findings are checked below***
If you are experiencing any of the following symptoms currently please check the symptom

GENERAL: □ Fever □ Weight loss/Weight Gain □ Chills □ Dizziness □ Night Sweats □Swollen Lymph Glands
SKIN: □ Bruises □ Itching □ Rash □ Hair loss □ Excessive hair growth
HEENT □ Vision Changes Sore Throat
BREAST: □ Swelling □ Lumps □ Pain □ Tenderness
LUNGS: □ Coughing □ Shortness of breath Wheezing
CARDIAC □ Fluttering Skipping Pounding Chest Pain
GASTROINTESTINAL □ Nausea Vomiting Diarrhea □ Constipation
URINARY: □ Blood in urine Frequency of urine □ Burning while urinating
BOWEL: □ Loss of control
BLADDER: □ Loss of control Hesitancy Frequency
NERVOUS SYSTEM □ Seizures □ Weakness □ Numbness □ Tingling □ Headaches □ Dizziness □ Loss of consciousness
PSYCHIATRY: Depression □ Suicidal thoughts □ Anxiety □ Memory loss Insomnia
SEXUAL: □ Impotency □ Erectile Disfunction Loss of interest
MUSCULOSKELETAL Soreness □ Fractures Sprain □ Swelling □ Stiffness
Other _____