DESERT SKY
SPINE & SPORTS MEDICINE

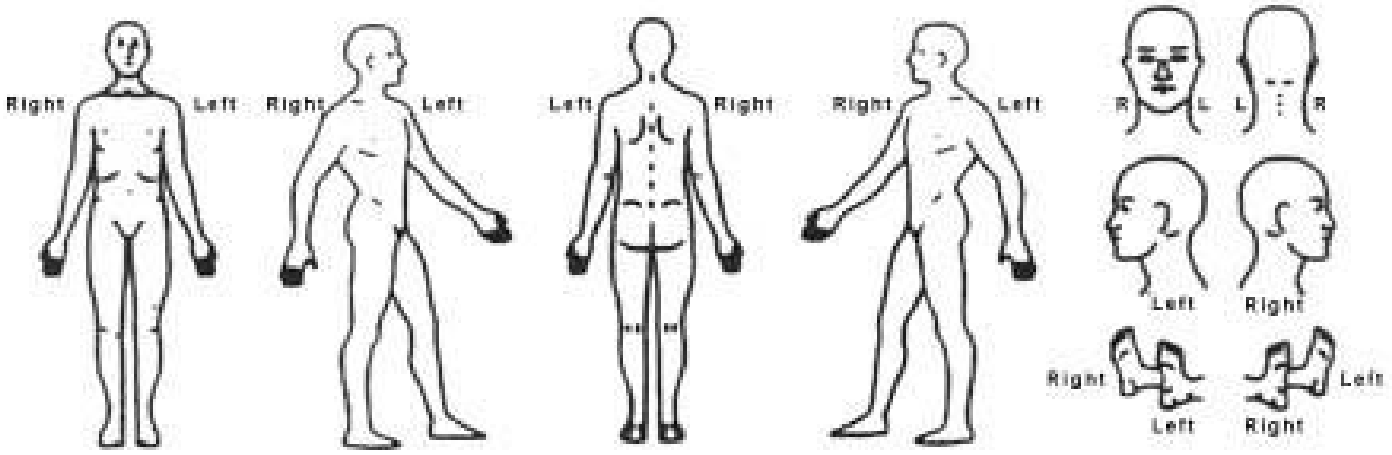
1521 E Tangerine Road Ste 201 – Oro Valley, AZ 85755
2530 E Wilcox Drive – Sierra Vista, AZ 85635
7493 E Tanque Verde Road – Tucson, AZ 85715

520-229-2080 desertskymedicine.com

NAME: _____ **DOB:** _____ **TODAY'S DATE:** _____

Briefly describe your main pain concern: _____

Use **X**'s to mark where you feel your pain on the diagrams below:



When did your pain originally begin?

○ At Work	Date: _____	○ Motor Vehicle Accident	Date: _____
○ Following Surgery	Date: _____	○ Illness	Date: _____
○ Pain Began Suddenly	Date: _____	○ Other: _____	Date: _____

What caused your injury? _____

Lowest Pain Level: ___/10 **Worst Pain Level**: ___/10 **Pain Level Today**: ___/10

How often does your pain occur?

○ Rarely	○ Occasionally	○ Most of the Time	○ Constantly

When is your pain the worst?

○ No specific time	○ Morning	○ Afternoon	○ Evening

Choose what best describe your pain:

○ Numb	○ Shooting	○ Radiating	○ Burning
○ Sharp	○ Dull	○ Electrical	○ Throbbing
○ Pounding	○ Aching	○ Tingling	○ Other: _____

Has the pain affected your mood? If yes, please describe: _____

Please indicate any symptoms associated with your pain:

○ Weakness	○ Numbness	○ Vomiting/Nausea	○ Fatigue
○ Bowel Incontinence	○ Urinary Incontinence	○ Sexual Dysfunction	○ Hair Changes
○ Color Change	○ Temperature Change	○ Nail Changes	○ Other: _____

Which of the following increases or decreases your pain level?

	Increases	Decreases		Increases	Decreases		Increases	Decreases
Heat	○	○	Bending	○	○	Walking	○	○
Cold/Ice	○	○	Lifting	○	○	Staying Busy	○	○
Standing	○	○	Pushing	○	○	Moving Around	○	○
Sitting	○	○	Tension	○	○	Twisting	○	○
Sit to Stand	○	○	Get out of Bed	○	○	Inactivity	○	○
Lying Down	○	○	Damp Weather	○	○	Alcohol	○	○
Cough/Sneeze	○	○	Gripping	○	○	Medication	○	○

Has the pain affected your sleep?

○ Usually ○ Occasionally ○ Rarely

How many hours do you sleep per night?

○ Less than 6 ○ 6 to 10 ○ More than 10

Do you have trouble falling asleep?

○ Usually ○ Occasionally ○ Rarely

Does your pain wake you during your sleep?

○ Usually ○ Occasionally ○ Rarely

Please check any of the following treatment modalities you have had and how it has helped:

	Poor	Fair	Good	Very Good	Excellent
Acupuncture	○	○	○	○	○
Chiropractor	○	○	○	○	○
Physical Therapy	○	○	○	○	○
Biofeedback	○	○	○	○	○
Counseling	○	○	○	○	○
Psychotherapy	○	○	○	○	○
Injection Therapy	○	○	○	○	○
TENS Unit	○	○	○	○	○
Other: _____	○	○	○	○	○

When did you initially seek treatment for your pain? _____

_____

List any other physicians you have seen for your current pain problem: _____

_____

Have you had any diagnostic tests done to evaluate your pain?

○ X-rays	Date: _____	○ Bone Scan	Date: _____
○ CT Scan	Date: _____	○ EMG/NCV	Date: _____
○ MRI	Date: _____	○ EEG	Date: _____
○ Genetic Testing	Date: _____	○ Myelogram	Date: _____
○ Other: _____	Date: _____	○ Other: _____	Date: _____

Please list any medications, supplements or vitamins you are currently taking or provide a list to us:

Medication Name	Strength	How Many	How Often

Past Medical History: Please check all that apply

○ Anemia	○ Clotting/Bleeding Disorder	○ Hepatitis	○ Murmur
○ Angina	○ COPD	○ High Blood Pressure	○ Pacemaker
○ Arthritis	○ Depression	○ HIV	○ Seizures
○ Asthma	○ Diabetes	○ Irregular Heart Rhythm	○ Sleep Apnea
○ Cancer	○ Emphysema	○ Kidney Disease	○ Stroke
○ Cataracts	○ GERD	○ Kidney Stones	○ Stomach Disorder
○ Cirrhosis	○ Heart Attack	○ Migraines	○ Thyroid Disease
○ Glaucoma	○ Other: _____	○ Other: _____	○ Other: _____

Past Surgical History: List any past surgeries or procedures

Surgery/Procedure	Date	Surgeon

Allergies: Please list any allergies, the reaction and the severity of the reaction, or check "No Known Allergies"

○ No Known Allergies

Medication Name	Reaction	Severity (Mild/Moderate/Severe)

Social History:

Martial Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Living Situation: ○ Alone ○ With Others: _____

Caffeine Consumption per Day: ○ None ○ _____ cups

Smoking Status: ○ Current Every Day Smoker – Packs per Day _____ ○ Never Smoked

○ Current Some Day Smoker – Cigarettes per Week _____ ○ Former Smoker – Quit _____

○ Chewing Tobacco – Times per Day _____ ○ E-Cigarette – Times per Day _____

Alcohol Consumption: ○ Never ○ _____ drinks per day/week/month ○ Quit _____

Have you ever been a recreational or IV drug user, including medical marijuana?

○ Never ○ Current ○ Quit _____ Type _____ How Long? _____ How Often? _____

Employment: Current Occupation: _____

Employment Status: ○ Full-Time ○ Part-Time ○ Student ○ Homemaker

○ Worker's Comp ○ Unemployed ○ Leave of Absence ○ Disability ○ Retired

If not currently working, when did you last work? _____

Would you return to work if you had less pain? ○ Yes ○ No

Have you or do you find it necessary to seek legal action regarding your current pain? ○ Yes ○ No

Attorney Name: _____ Address: _____ Phone: _____

Family History: Please check all that apply to immediate family members only and their relation to you

○ Back Disorder _____ ○ Diabetes _____

○ Thyroid Disorder _____ ○ Stroke _____

○ High Blood Pressure _____ ○ Heart Disease _____

○ Cancer _____ ○ Migraines _____

Do you have a living will or power of attorney? ○ No ○ Yes (Please provide us with a copy)

Your Contact Information: Email Address: _____ Preferred Phone #: _____

Emergency Contact: Name: _____ Relation to You: _____ Phone #: _____

Primary Care: Name: _____ Location: _____ Phone #: _____

Referring Provider: Name: _____ Location: _____ Phone #: _____