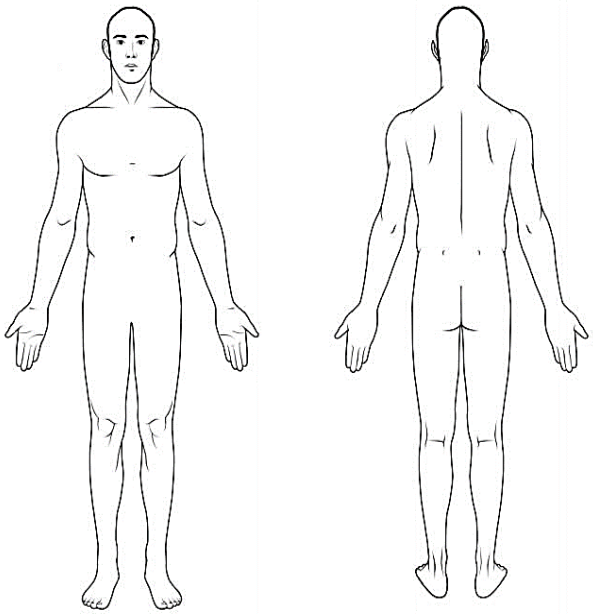
RestorePDX FUNCTION- PERFORMANCE -LIFE

Patient Name: **DOB:**

Please mark the picture where your pain is located:



Please rate your pain intensity on a scale of 0 to 10, where 0=no pain and 10= incoherent, passing out, the worst pain possible. Circle the appropriate number below:

No pain	0	1	2	3	4	5	6	6	7	8	9	10	Worst Pain

Pain Description

Do you have any pain, numbness or tingling? □ I have pain □ I have numbness/tingling □ I have neither

What is the most painful/numb area you would like us to address primarily?

When did your pain start?

Are you currently working? □ Full time □ Part Time □ I am not currently working - If so, when was your last working date? - Please specify

Was there a specific injury within hours of the onset of your pain? □ No □ Yes
- If yes, please select all that apply: □ Motor Vehicle Accident □ Work Injury □ Fall □ Lifting □Unknown

Was this spontaneous onset (no specific injury)? □ Yes □ No

Have you ever been to the ER or Urgent Care for this problem?

Have any other doctors treated you for this problem?

Please select any prior medications you have tried:

□ Ibuprofen/Advil	□Aleve/Naproxen	□ Lyrica	□ Fentanyl	□ Oxycodone	□ Valium
□ Ultracet	□ Celebrex	□ Mobic	□ Dilaudid	□ Hydrocodone	□ Tramadol
□ Flexeril	□ Gabapentin	□ Skelaxin	□ OxyContin	□ Other (Please Specify):	

Details of Pain Symptoms

How severe is the problem for you? □ Mild □ Moderate □ Severe

Is the problem: □ Getting Better □ Getting Worse □ Unchanged

What alleviates your pain? □Sitting □ Standing □ Lying down □ Stretching □ Other (Please Specify):

What aggravates your pain? □ Sitting □ Standing □ Lying down □ Stretching □ Other (Please Specify):

Have you experienced any of the following? □ Bowel/Bladder control issues

□ Numbness in legs/feet □ Weakness in legs/feet □ Weakness in arms/legs □ Numbness in arms/hands

Prior Treatments Tried

Treatments Tried	Helpful? – please circle	Date Started	Date Stopped	Adverse reactions
Injection(s)	Yes No			
Brace(s)	Yes No			
Physical Therapy	Yes No			
Chiropractor	Yes No			
Acupuncture	Yes No			
TENS	Yes No			
Biofeedback	Yes No			
Psychological Help	Yes No			
Other:	Yes No			
□ I have not had any prior treatments for my current complaints				

Prior Imaging/Diagnostic Tests

Imaging/Test	Body Part	Facility	Month & Year
MRI			
X-Ray			
CT Scan			
Ultrasound			
EMG/Nerve Conduction Study			
Bone Scan			
Other:			
□ I have not had any prior imaging or diagnostic tests			

Please list any clinics you have been to outside of RestorePDX for your pain:

Are you currently under a pain contract with any providers? □ No □ Yes – If yes, Whom?

RestorePDX FU N C TI ON- PERFO RM A N CE -L I FE

Please indicate any that you have experienced in the last six months:

General	**Skin**	**Urinary**
☐ Fatigue	☐ Rashes/Sores	☐ Pain With Urination
☐ Insomnia	☐ Easy Bruising	☐ Loss of Urine
☐ Stress	☐ Itching	☐ Odor Changes
☐ Weight Loss/Gain	☐ Dryness	☐ Frequency/Urgency
☐ Snoring	☐ Thinning of Hair	☐ Incomplete Emptying
☐ Mental Fog	☐ Changes in Nails	**Hormones**
☐ Recent Illness	**Psychiatric**	Changes in Menses
Neurologic	☐ Mood Changes	☐ Painful/Heavy Menses
☐ Dizziness	☐ Anxiety	☐ PMS
☐ Excessive Sleepiness	☐ Depression	☐ Low Sex Drive
☐ Fainting	☐ Thoughts of Self Harm	☐ Vaginal Dryness
☐ Headaches	☐ Increased Alcohol/Drug Usage	☐ Hot Flashes/ Night Sweats
☐ Seizures/Tremor	**ENT**	☐ Lower Muscle Mass
☐ Mental Changes	☐ Nose Bleed	**Chest/Lung**
☐ Memory Changes	☐ Sinus Congestion	☐ Cough
Eyes	☐ Sore Throat	☐ Chest Congestion
☐ Eye Pain	☐ Bleeding Gums	☐ Wheezing
☐ Light Sensitivity	☐ Lump in Throat	**Musculoskeletal**
☐ Changes in Vision	☐ Ringing in Ears	☐ Back Pain
☐ Dryness/Tearing	☐ Mouth/Jaw Pain	☐ Neck Pain
Cardiovascular	**Digestive**	☐ Joint Pain:
☐ Chest Pain	☐ Abdominal Pain	
☐ Irregular Beating	☐ Constipation	☐ Numbness
☐ Foot/Hand Swelling	☐ Diarrhea	☐ Tingling/Burning
☐ Cold Hands/Feet	☐ Bloating	☐ Weakness
☐ Short of Breath	☐ Heartburn	☐ Change in Exercise Tolerance
☐ High Blood Pressure	☐ Nausea/Vomiting	
☐ Low Blood Pressure	☐ Loss of Bowel Control	