OKLAHOMA CENTER FOR
SPINE & PAIN
SOLUTIONS

S. Pahamark, ARNP

9821 S. May Ave Suite B
Oklahoma City, OK 73159
(405) 631-4263

PATIENT HISTORY

Date: ____________________

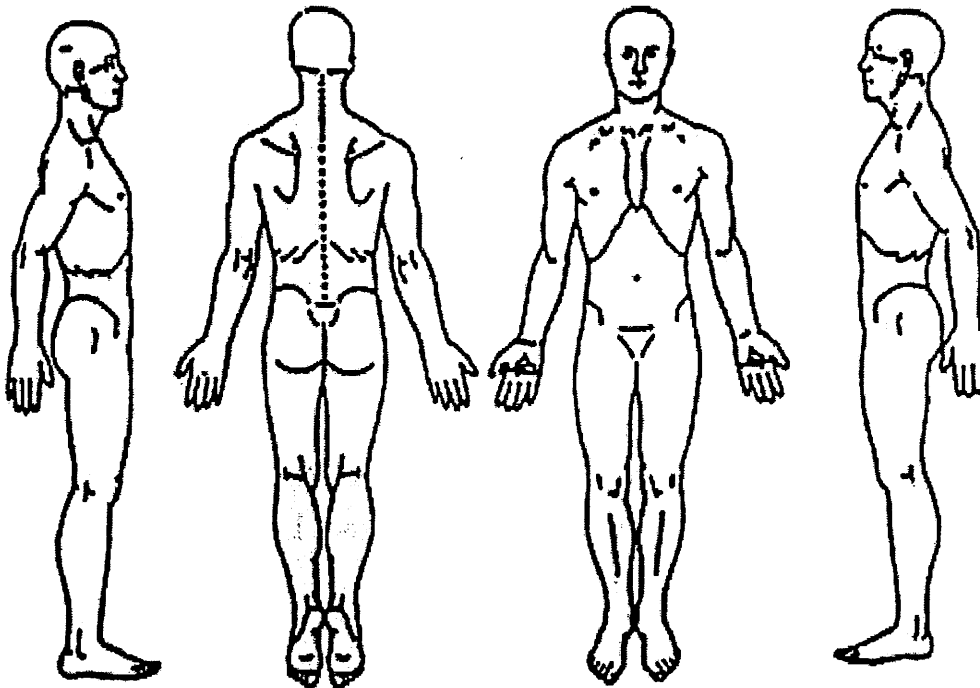
Last Name: ______________________ First Name: ____________________________
Height: _________ Weight: _________ Age: _________ Sex: _________

Referred By: _______________________________ Fax #: _____________________

CHIEF COMPLAINTS: **DATE PROBLEM BEGAN:** ___________________
1. ____
2. ____
3. ____
4. ____

1. SHADE IN THE AREAS ON THE DIAGRAM WHERE YOUR PAIN IS LOCATED

Mark numbness with: ====== Pins and needles with: ooooo Burning with: xxxxx Stabbing with: /////



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HISTORY OF PRESENT ILLNESS

2. WHERE IS YOUR PAIN LOCATED? (Check all that apply)

Low Back ________% Mid Back __________% Upper Back ________% Neck ___________%

Left Buttock _______% Right Buttock ________% Left Leg __________% Right Leg _________%

Left Shoulder ______% Right Shoulder ________% Left Arm _________% Right Arm _________%

_______% other/ Explain ____

3. IS YOUR PAIN THE RESULT OF AN ACCIDENT?

_______Accident at Work _______Accident at Home _______Motor Vehicle Accident

_______ Is this a Worker's Compensation claim? Date of Accident ___________________

______ Are you involved in any litigation, worker's compensation, or disability claim involving your injury?

If so, who is your lawyer? ____

4. IS YOUR PAIN: Constant ______________ Intermittent ______________

5. ON A RATING SCALE 1-10 HOW SEVERE IS YOUR PAIN? (10 being the most excruciating)

Back Pain: __________ Neck Pain: __________ Arm Pain: __________ Leg Pain: _________

Does your pain wake you up or keep you from falling asleep? YES NO

6. DOES ANY OF THE FOLLOWING MAKE YOUR PAIN FEEL BETTER?

______ Relaxation ______ Sitting ______ Standing ______Lying down

______ Heat ______ Cold ______ Walking/Exercise ______ Alcoholic drinks

______ Oral Medications ______ Sexual activity ______ Other Explain______________________________

7. DOES ANY OF THE FOLLOWING MAKE YOUR PAIN FEEL WORSE?

_______Coughing/Sneezing ______Sitting ______Standing

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______Lying down ______ Sexual activity ______ Walking/Exercise

______Other Explain ____

8. HAVE YOU HAD ANY OF THE FOLLOWING FOR THIS PROBLEM?

______Lumber MRI ______Cervical MRI ______X-Rays ______Discogram

______EMG ______CAT Scan ______Myelogram

9. HAVE YOU HAD ANY PREVIOUS TREATMENT FOR THIS PROBLEM?

______Physical Therapy Did it: ______ Help ______ Hurt ______Neither

______Epidural Injections Did they: ______ Help ______ Hurt ______Neither

______Surgery Explain type:____

______Other Explain:____

PAST MEDICAL HISTORY

1. Past or current illnesses (please check all that apply)

______Heart Disease ______Hepatitis ______Rheumatoid Arthritis ______Osteoarthritis

______Heart Attack ______Thyroid Condition ______High Blood Pressure ______ Stroke/TLA

______ Gout ______Blood Clots ______Bleeding disorder ______Easy Bruising

______ Asthma ______Cancer ______ Seizures ______ Tuberculosis

______ Heart Failure ______Ulcers ______ HIV/AIDS ______ Diabetes ______Scoliosis

______ Other/Explain: ____

2. Please list all previous surgeries and dates

1. ____
2. ____
3. ____

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4. ______________________________
5. ______________________________

3. Do you have any allergies? ______ If so, please explain: ______________________________

____

REVIEW OF SYSTEMS

(Check all that apply)

Weakness:

______ Left Arm ______Left Leg ______Left Hand
______Right Arm ______Right Leg ______Right Hand

Has the weakness increased over the last six months? ______________________________

Do you now have or have you had any of the following:

______ Loss of consciousness ______Headaches ______Swelling ______Paralysis
______Shortness of breath ______Tremors ______Cough ______Chest Pains
______Difficulty Walking ______Night sweats ______Heart palpitations ______Weight loss
______Problem with balance ______Loss of bowel or bladder control
______Other/Eplain:______________________________

____

____

CURRENT MEDICATIONS:

1. ______________ 4. ______________ 7.______________

2. ______________ 5. ______________ 8.______________

3. ______________ 6. ______________ 9.______________

FAMILY MEDICAL HISTORY: (Please check all that are found in your family)

	FATHER	MOTHER	SISTER	BROTHER	GRANDPARENTS
Allergies					
Arthritis					
Asthma					
Cancer					
Diabetes					
Epilepsy					

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High Blood Pressure					
Other (specify)					

SOCIAL MEDICAL HISTORY:

Occupation: ____________________

Currently Working? ______YES ______NO If no, last date worked? ____________________

______Married ______Divorce ______Single

Do you smoke? ____Yes____No # of Packs/Day__________ For how many years? __________

Do you drink alcohol? ____ Yes____ No Amount? ____________How often? ______________

Do you use drugs for recreation? ____Yes____No Type? ____________________

Other information: ____________________

Signature: ______________________________ Date: ____________________

Provider Signature: ______________________________ Date: ____________________