NATURAL HEALING FAMILY MEDICINE

LORI WIESER N.D.
NATUROPATHIC PHYSICIAN

PAIN TREATMENT INTAKE FOR NEW PATIENT'S

Last Name:_______________ First Name:______________ DOB:___/___/___ Date:___/___/___
Address:_________________________________ City:________________ State:_____ Zip:__________
Gender:_____________ Phone:( ) __________ Email:_______________________________________
Name of Family Doctor:_____________________________ Dr. Wieser
Address:_________________________________ City:________________ State:_____ Zip:__________
Phone:( ) ___________ Fax:( ) ____________

As a professional courtesy, we would like to keep your family doctor up to date with your therapy progress. Is it ok for us to send your family doctor periodic updates? Yes No

Who may we contact in case of an emergency?____
Name:________________________ Relationship:_____________________ Phone:( ) ___________

PLEASE CHECK BELOW IF IT APPLIES TO YOU:

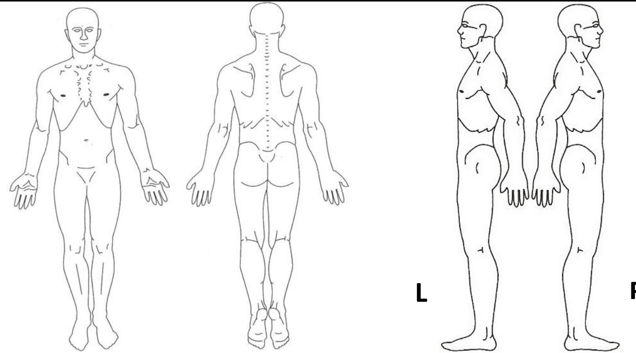
Do you have allergies to meds/herbs? Penicillin Sulfa/Bactrim Codeine	Explain Reaction_______________________________	
Do you have allergies to anesthetic? Lidocaine Procaine Novacaine	Explain Reaction_______________________________	
Are you a Diabetic?	Current fasting blood sugars_______________________	
Are you, or have you been a Smoker?	How long:______________________	Quit date:_____________________

PLEASE CHECK ALL THAT APPLY TO YOU	PLEASE LIST THE LAST TIME OF USE
Do you use Corticosteroid injections for pain?	
Do you take oral steroids for pain?	
Do you take inhaled steroids for asthma and allergies?	
Do you currently use fish oil?	
Do you currently use NSAIDS? (Aspirin, Ibuprofen/Advil)	
Do you currently use a COX2 Inhibitor? (Celebrex, Vioxx, Meloxicam)	

In the boxes below you will be asked to list your TOP 3 PAIN/INJURIES (**PAIN/INJURY #1** being the one you need fixed the most), and answer questions describing the PAIN/INJURY and how it affects your life. If you have more than 3 problems and would like Dr. Wieser to know about them, go to our website www.naturalhealingfamilymedicine.com, click on the "contact us" link, and download and fill out NHFM Pain Treatment Extra Pain Areas 4,5,6, and bring it to your first visit.

PAIN/INJURY #1 Chief Complaint:__________________________					
Work Related Injury	Recreational Injury	Motor Vehicle Injury	Sports Injury	Pain Management	Other________________________
Acute (less than 30 days)		Subacute (1 - 6 months)		Chronic (more than 6 months)	
Approx date/time of injury:					
What caused the injury/pain:_______________________________________					
How did your current episode begin?	Suddenly	Gradually			
Check all that apply					
My pain is:	Numb	Throbbing	Aching	Burning	Stabbing Dull
Shooting	Sharp	Cramping	Tingling	Radiating (where):________________	
What makes it better (rest, massage):__________________________________ What makes it worse (work, exercise):__________________________________					
Has your current pain gotten:	Better	Worse	Unchanged		

Please circle the area of Pain/Injury #1 on the figure(s) below



Please circle the number which best describes Pain/Injury #1. **0** is NO PAIN - **10** is THE MOST PAIN YOU HAVE EVER BEEN IN

What is your pain right now?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
What is your typical or average pain?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

HISTORY OF IMAGING: Please select each box that applies to Pain/Injury #1

X-Ray MRI Ultrasound CT EMG (nerve conduction study)

HISTORY OF TREATMENT

Please select each method of treatment that applies to Pain/Injury #1. Mark "C" if you are CURRENTLY using this method, mark "P" if you have used the method in the PAST ". In the "Improvement Rating" section please rate with 1=Better, 2=No Change, 3=Worse

P	C	METHOD	FREQUENCY/ # OF TIMES	IMPROVEMENT RATING
		Primary Care Physician		
		Chiropractic		
		Massage		
		Physical Therapy		
		Acupuncture		
		Yoga/Exercise		
		Surgery		
		Ultrasound		
		Brace/Splint		
		Joint Injections:where_______________________________		
		Trigger Point Injections:where_______________________		
		Epidural Injection (spinal cord)		
		Surgery:where______________________________________		
		Radiofrequency Ablations		
		Over-the-counter medications		
		Prescription Medications		
		Vitamins/Herbs		
		Other:____		

If you have copies of your imaging results (ie: MRI, X-Ray, CT Scan), please bring to the visit.

Below please list your Activity of Daily Life (ADL) **MOST AFFECTED** by Pain/Injury #1.
Helping this ADL will be our primary goal. (ADL: brush teeth, tie shoes, walk, pick up kids)

ADL:

Do you need medication(s) to perform this ADL? No Yes____

Goals for ADL:____

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PAIN/INJURY #2 **Chief Complaint:**____________________________

Work Related Injury	Recreational Injury	Motor Vehicle Injury	Sports Injury	Pain Management	Other____________________

Acute (less than 30 days) Subacute (1 - 6 months) Chronic (more than 6 months)

Approx date/time of injury:

What caused the injury/pain:____

How did your current episode begin? Suddenly Gradually

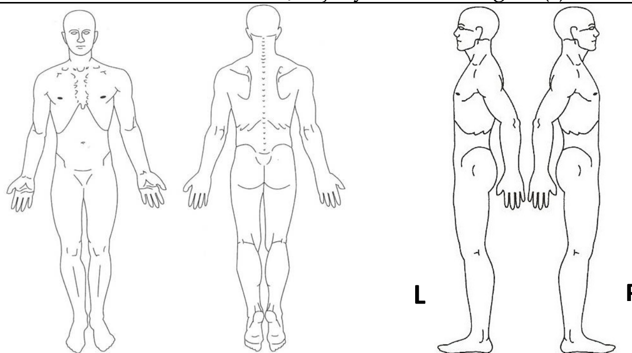
Check all that apply

My pain is: Numb Throbbing Aching Burning Stabbing Dull
Shooting Sharp Cramping Tingling Radiating (where):______________________

What makes it better (rest, massage):______________________________________
What makes it worse (work, exercise):______________________________________

Has your current pain gotten: Better Worse Unchanged

Please circle the area of Pain/Injury #2 on the figure(s) below



Please circle the number which best describes Pain/Injury #2. **0** is NO PAIN - **10** is THE MOST PAIN YOU HAVE EVER BEEN IN

What is your pain right now?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
What is your typical or average pain?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

HISTORY OF IMAGING: Please select each box that applies to Pain/Injury #2

X-Ray MRI Ultrasound CT EMG (nerve conduction study)

HISTORY OF TREATMENT

Please select each method of treatment that applies to Pain/Injury #2. Mark "C" if you are CURRENTLY using this method, mark "P" if you have used the method in the PAST ". In the "Improvement Rating" section please rate with 1=Better, 2=No Change, 3=Worse

P	C	METHOD	FREQUENCY/ # OF TIMES	IMPROVEMENT RATING
		Primary Care Physician		
		Chiropractic		
		Massage		
		Physical Therapy		
		Acupuncture		
		Yoga/Exercise		
		Surgery		
		Ultrasound		
		Brace/Splint		
		Joint Injections:where____________________		
		Trigger Point Injections:where______________		
		Epidural Injection (spinal cord)		
		Surgery:where________________________		

		Radiofrequency Ablations		
		Over-the-counter medications		
		Prescription Medications		
		Vitamins/Herbs		
		Other:________________________________		

If you have copies of your imaging results (ie: MRI, X-Ray, CT Scan), please bring to the visit.

Below please list your Activity of Daily Life (ADL) **MOST AFFECTED** by Pain/Injury #2.
Helping this ADL will be our primary goal. (ADL: brush teeth, tie shoes, walk, pick up kids)

ADL:

Do you need medication(s) to perform this ADL? No Yes________________________________

Goals for ADL:________________________________

PAIN/INJURY #3 Chief Complaint: ____________________

Work Related Injury	Recreational Injury	Motor Vehicle Injury	Sports Injury	Pain Management	Other____________

Acute (less than 30 days) Subacute (1 - 6 months) Chronic (more than 6 months)

Approx date/time of injury:

What caused the injury/pain:________________________________

How did your current episode begin? Suddenly Gradually

Check all that apply

My pain is: Numb Throbbing Aching Burning Stabbing Dull
Shooting Sharp Cramping Tingling Radiating (where):____________________

What makes it better (rest, massage):________________________________

What makes it worse (work, exercise):________________________________

Has your current pain gotten: Better Worse Unchanged

Please circle the area of Pain/Injury #3 on the figure(s) below

L R

Please circle the number which best describes Pain/Injury #3. **0** is NO PAIN - **10** is THE MOST PAIN YOU HAVE EVER BEEN IN

What is your pain right now?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
What is your typical or average pain?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

HISTORY OF IMAGING: Please select each box that applies to Pain/Injury #3

X-Ray MRI Ultrasound CT EMG (nerve conduction study)

HISTORY OF TREATMENT

Please select each method of treatment that applies to Pain/Injury #3. Mark "C" if you are CURRENTLY using this method, mark "P" if you have used the method in the PAST ". In the "Improvement Rating" section please rate with 1=Better, 2=No Change, 3=Worse

P	C	METHOD	FREQUENCY/ # OF TIMES	IMPROVEMENT RATING
		Primary Care Physician		

		Chiropractic		
		Massage		
		Physical Therapy		
		Acupuncture		
		Yoga/Exercise		
		Surgery		
		Ultrasound		
		Brace/Splint		
		Joint Injections:where______________________________		
		Trigger Point Injections:where______________________		
		Epidural Injection (spinal cord)		
		Surgery:where____________________________________		
		Radiofrequency Ablations		
		Over-the-counter medications		
		Prescription Medications		
		Vitamins/Herbs		
		Other:____		

If you have copies of your imaging results (ie: MRI, X-Ray, CT Scan), please bring to the visit.

Below please list your Activity of Daily Life (ADL) **MOST AFFECTED** by Pain/Injury #3.
Helping this ADL will be our primary goal. (ADL: brush teeth, tie shoes, walk, pick up kids)

ADL:

Do you need medication(s) to perform this ADL? No Yes____

Goals for ADL:____

If you have more than 3 issues you would like to bring to Dr. Wieser's attention, please fill out NHFM Pain Treatment Extra Pain Areas 4,5,6 (located at naturalhealingfamilymedicine.com), and bring it to your first visit.

Occupational History		
Are you currently employed?	No	Yes (if yes explain)____
What is your job/profession?____		

Family History			
Married/Living With Significant Other	Divorced	Widowed	Single
Do you have any children?	No	Yes: if yes, How many?_________ How Old?_________________________	
Do any of your children live at home?	No	Yes: if yes, How many?___________________________________	

Social History					
Do you drink alcohol?	No	Yes: if yes, How much per day?__________________________	Do you drink caffeine?	No	Yes: if yes, How much per day?______________________
Do you use tobacco?	No	Yes: if yes, How much per day?__________________________	Do you use illegal drugs?	No	Yes: if yes, How much & when?______________________

Exercise History		
I do not exercise regularly	I exercise 1-2 times per week	I exercise 3-5 times per week
I stretch regularly	I do weight lifting at gym/home	I do cardiovascular work outs
I am willing to exercise	I am not willing to exercise	I do regular sports activities

Fractured/ Broken Bones History I have NO history of broken/fractured bones.					
Region	**Month/Year**	**Region**	**Month/Year**	**Region**	**Month/Year**
Spinal Vertebra		Skull		Arm, leg, hand, or foot	
Collar bone, ribs, or sternum		Pelvis or hip bones		Other:_______________	

Surgery History I have NEVER had a surgical procedure.			
Surgery	**Year**	**Surgery**	**Year**
Spine surgery (neck, back, pelvis)		Abdominal, chest, appendix	
Disc surgery in neck or back		Gallbladder, liver, stomach, kidney	
Heart		Cancer (any type)	
Head, brain, spinal cord, nerve		Hernia (inguinal or hiatal)	
Shoulder, arm, hip, leg		Other:________________________________	

History of Medications I am currently NOT taking medications.			
Please list allergies to medications:____			
NAME	**DOSE**	**NAME**	**DOSE**

History of Vitamins/ Supplements/ Herbs I am currently NOT taking vitamins/supplements/herbs.			
NAME	**DOSE**	**NAME**	**DOSE**

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NOTE: Below is a list of symptoms that may seem unrelated to the purpose of your visit. Knowledge of these conditions may influence the type of treatment/therapy you receive.

Please circle "P" for PAST and "C" for CURRENT.

		CONSTITUTIONAL
P	C	Chills
P	C	Daytime Drowsiness
P	C	Fatigue
P	C	Fever
P	C	Night Sweats
P	C	Weight Gain
P	C	Weight Loss
P	C	Other:

		EAR/ NOSE/ THROAT
P	C	Difficulty/ Loss of Hearing
P	C	Ringing in the Ears
P	C	Frequent Ear Aches
P	C	Discharge from the Ear
P	C	Attacks of Vertigo
P	C	Sinus Trouble
P	C	Nasal Blockage
P	C	Frequent Sneezing
P	C	Frequent Sore Throat
P	C	Snoring
P	C	Change in Voice Quality
P	C	Sleep Apnea
P	C	Difficulty in Swallowing
P	C	Nose Bleeds
P	C	Other:

		HEART & CIRCULATION
P	C	Heart Attack
P	C	High Blood Pressure
P	C	Heart Murmur
P	C	Chest Discomfort
P	C	Heart Failure or Fluid on Lungs
P	C	Palpitations, Racing or Pounding
P	C	Shortness of Breath w/Activity
P	C	Stroke/ Mini Stroke or TIA
P	C	Blood Clot in Artery or Vein
P	C	"Black Out Spells"
P	C	Aneurysm of any Blood Vessel
P	C	Swelling of Legs
P	C	Heart Surgery
P	C	Heart Palpitations
P	C	Other:

		KIDNEY/ URINARY
P	C	Kidney Disease or Failure

		EYES
P	C	Wear Glasses or Contacts
P	C	Blindness
P	C	Cataracts
P	C	Glaucoma
P	C	Other:

		RESPIRATORY
P	C	Asthma or Wheezing
P	C	Bronchitis or Chest Cold
P	C	Cough
P	C	Coughing up Blood
P	C	Shortness of Breath
P	C	Other:

		STOMACH/ GASTROINTESTINAL
P	C	Ulcer
P	C	Frequent Heartburn or Indigestion
P	C	Hiatal Hernia & or Acid Reflux
P	C	Poor Appetite
P	C	Gall Bladder Attacks
P	C	Frequent Diarrhea
P	C	Chronic Constipation
P	C	Bright Blood Bowels or Rectum
P	C	Abnormal Stool
P	C	Liver Disease or Jaundice
P	C	Other:

		ENDOCRINE/ METABOLISM
P	C	Thyroid Disorder
P	C	Unusual Hair Loss or Growth
P	C	Goiter
P	C	Diabetes
P	C	Other:

		ALLERGIES
P	C	Anaphylaxis
P	C	Food Intolerance
P	C	Itching
P	C	Nasal Congestion
P	C	Rash
P	C	Sneezing
P	C	Other:
P	C	Other:

		PSYCHOLOGICAL
P	C	Anxiety
P	C	Loss of Change in Appetite

P	C	History of Kidney Dialysis	P	C	Behavioral Change
P	C	Kidney Stones or Infection	P	C	Bi-Polar Disorder
P	C	Pain or Burning with Urination	P	C	Confusion
P	C	Trouble Starting Urinary Stream	P	C	Convulsions
P	C	Dribbling or Incontinence	P	C	Depression
P	C	Frequent Night Urination	P	C	Insomnia
P	C	Bladder Infections During Past Year	P	C	Memory Loss
P	C	Blood in Urine During Past Year	P	C	Mood Change
P	C	Other:	P	C	Other:
NERVOUS SYSTEM			**BLOOD**		
P	C	Headache	P	C	Bleeding or Brushing Tendency
P	C	Epilepsy or Seizures	P	C	Previous Blood Transfusion
P	C	Date of Last Seizure _______________	P	C	History of Hepatitis
P	C	Other Nervous Disorder	P	C	Other:
P	C	Other:	**MUSCULOSKELTAL**		
MEN ONLY			P	C	Neck Pain
P	C	Testicular Swelling	P	C	Joint Pain
P	C	Prostate Problems	P	C	Osteoarthritis
P	C	Frequent Urination	P	C	Back Pain
P	C	Other:	P	C	Muscle Spasms
WOMEN ONLY			P	C	Rheumatoid Arthritis
P	C	Painful Periods	P	C	Joint Injury
P	C	Excessive Flow	P	C	Tennis Elbow
P	C	Irregular Cycles	P	C	Carpal Tunnel Syndrome
P	C	Vaginal Burning	P	C	Bursitis
P	C	Hot Flash	P	C	Other:
P	C	Other:	**IMMUNE SYSTEM**		
Y	N	Are you pregnant?	P	C	Auto-Immune Disorder:
			P	C	Weakened Immune System
			P	C	Other: