MANHATTAN RESTORATIVE HEALTH SCIENCES™

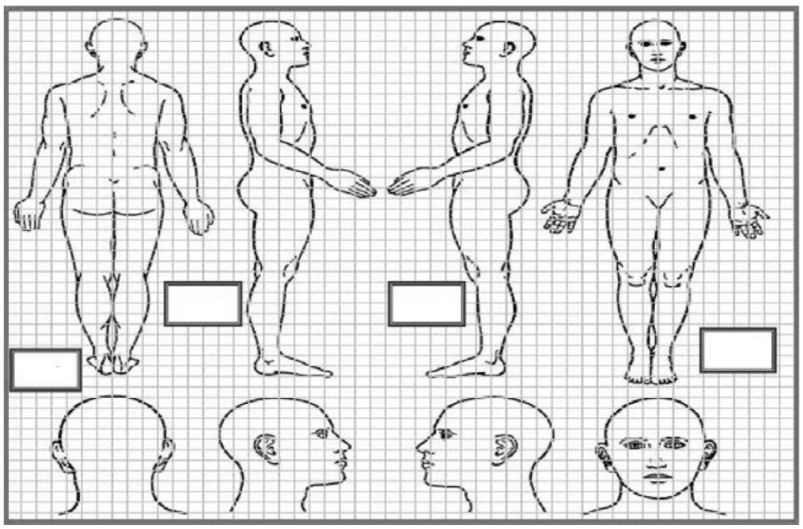
Dr. Tim Canty M.D.
Double-Board Certified Pain Management Specialist
Comprehensive Spine and Pain Center of New York
917-524-7246 / MRHSclinics.com

MEDICAL HISTORY FORM

NAME:_____ DATE: _____

DATE OF BIRTH:_____ AGE:_____

Please mark/shade on the picture below where your pain is located and where it travels.



PAIN HISTORY

1. WHEN did your pain begin? (Please be as specific as possible - for example: "4 months ago"):

2. How did your pain begin? (Please check one and describe below):

__ PAIN JUST STARTED BY ITSELF
__ INJURY OR ACCIDENT AT WORK
__ INJURY OR ACCIDENT AT HOME
__ MOTOR VEHICLE ACCIDENT – DATE OF ACCIDENT _____
__ OTHER (SPECIFY): _____

3. What does your pain feel like? (Please circle):

1	2	3	4
SHARP	DULL	ANNOYING	PENETRATING
BURNING	ACHING	MISERABLE	PIERCING
ELECTRICITY	SORE	INTENSE	TIGHT
SHOOTING	HURTING	UNBEARABLE	NUMB
STABBING	HEAVY	TROUBLESOME	SQUEEZING
LANCINATING	TENDER	NONE	COOL
TINGLING	TIRING		COLD
THROBBING	SICKENING		NAUSEATING
POUNDING	TERRIFYING		AGONIZING
CRAMPING	PUNISHING		DREADFUL
CRUSHING	BLINDING		TORTURING
PULLING			

4. Circle all that apply - Is your pain...

CONSTANT INTERMITTENT IMPROVING WORSENING

5. Circle which activities or body positions bring on or WORSEN YOUR PAIN:

SITTING STANDING WALKING LAYING DOWN DAILY ACTIVITIES LIFTING EXERCISE
COUGHING/SNEEZING HOT/COLD WEATHER DAMP WEATHER BOWEL MOVEMENT

OTHER (FILL IN): _____

Circle which activities or body positions seem to IMPROVE YOUR PAIN:

SITTING STANDING WALKING LAYING DOWN BED REST CHIROPRACTOR
PHYSICAL THERAPY HEAT/COLD RELAXATION TRAINING MEDICATIONS EXERCISE
ACUPUNCTURE MASSAGE THERAPY BIOFEEDBACK INJECTIONS

OTHER (FILL IN): _____

6. Associated symptoms (check all that apply):

__ WEAKNESS OF THE ARM(S)
__ WEAKNESS OF THE LEG(S)
__ NUMBNESS IN THE ARM(S)
__ NUMBNESS IN THE LEGS(S)
__ LOSS OF BLADDER / BOWEL CONTROL
__ COOL, PALE SKIN
__ SKIN COLOR CHANGES
__ DIFFICULTY SLEEPING
__ WEIGHT LOSS
__ OTHER: _____

7. Which TREATMENTS have you had for your pain (check all that apply):

TREATMENT	HELPFUL?	WHEN WAS THIS DONE?
__ PAIN KILLERS	YES / NO	_____
__ ANTI-INFLAMMATORY MEDS	YES / NO	_____
__ PHYSICAL / CHRIOPRACTIC THERAPY	YES / NO	_____
__ CORTISONE SHOTS	YES / NO	_____
__ EPIDURAL INJECTIONS	YES / NO	_____
__ OTHER (DESCRIBE) _____	YES / NO	_____

8. List any medications you have taken in the past which did NOT help:

_____

9. PAST MEDICAL & SURGICAL HISTORY: Have you ever been diagnosed with or treated for any of the following health problems? (Please check and circle all that apply):

__ ANGINA / CHEST PAIN
__ ANGIOPLASTY / STENT FOR BLOCKED ARTERY
__ ANXIETY, DEPRESSION, OR PANIC DISORDER
__ ARRHYTHMIA / ATRIAL FIBRILLATION / CARDIAC ARREST
__ ARTHRITIS (TYPE: OSTEO / RHEUMATOID)
__ ASTHMA / WHEEZING
__ BIPOLAR DISORDER
__ BLEEDING DISORDER (HEMOPHILIA , ITP, ETC)
__ CANCER (TYPE: _____)
__ CHRONIC GOUGH
__ CONGESTIVE HEART FAILURE (YEAR: _____)
__ DEEP VENOUS THROMBOSIS / BLOOD CLOT LEG
__ DIABETES (TYPE: I / II)
__ DRUG OR ALCOHOL ABUSE / ADDICTION
__ EMPHYSEMA, CHRONIC BRONCHITIS, OR COPD
__ FIBROMYALGIA
__ HEADACHE (MIGRAINE, CLUSTER, OR TENSION?)
__ HEART ATTACK (YEAR: _____)
__ HEPATITIS (CIRCLE TYPE: A / B / C)
__ HIGH BLOOD PRESSURE
__ HIV OR AIDS
__ IMPLANTABLE DEFIBRILLATOR
__ KIDNEY FAILURE / DIALYSIS
__ LIVER DISEASE / CIRRHOSIS
__ NEUROPATHY (TYPE: _____)
__ OBESITY
__ PACEMAKER
__ PARALYSIS (DESCRIBE: _____)
__ PREVIOUS SUICIDE ATTEMPT
__ PULMONARY EMBOLISM / BLOOT CLOT TO THE LUNG
__ SEIZURE OR EPILEPSY
__ SICKLE CELL DISEASE
__ STOMACH OR DUODENAL ULCER (YEAR: _____)
__ STROKE OR TIA
__ THYROID DISEASE (UNDER OR OVERACTIVE?)

10. On a scale of 0-10 (0 is no pain, 10 is worst imaginable) what is your pain (circle)?

    ON AVERAGE: 0 1 2 3 4 5 6 7 8 9 10
    AT ITS WORST: 0 1 2 3 4 5 6 7 8 9 10

11. Please list any SURGICAL operation(s) you have had in the past:

    YEAR OPERATION

12. Please list any DRUGS, contrast dyes, medications, foods that you are ALLERGIC to:

13. Please list all CURRENT MEDICATIONS with the doses that you are taking.
    List all BLOOD THINNERS*

14. SOCIAL HISTORY (check and fill in answers):

    Do you smoke? [ ] Yes [ ] No [ ] Quit If yes, how much? _____How many years? _____
    Do you drink alcohol? [ ] Yes [ ] No If yes, how much? _____
    Do you have any history of using Marijuana, Cocaine, Heroin, or any other illegal drugs?
    [ ] Yes [ ] No If yes, which drugs? _____
    Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed
    Occupation: _____
    Work Status: [ ] Working [ ] Not working [ ] Retired [ ] Disabled [ ] Unemployed
    Reason and date of disability: _____

15. YOUR HEIGHT: _____ WEIGHT: _____

Your doctor will complete the rest of this form

Physical: Impression:

Plan:

_____ Tim Canty, M.D.