Your completed paperwork helps our physicians get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please contact our office at (229)-891-9548 if you have questions on how to complete any section of this form.
Mark the areas on your body where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas.

<table>
<thead>
<tr>
<th>Pin &amp; Needles</th>
<th>Burning</th>
<th>Aching</th>
<th>Stabbing</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>ooo</td>
<td>xxx</td>
<td>^^^</td>
<td>///</td>
<td>###</td>
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</tbody>
</table>

**Pain Chart**

**Pain Score:** Please indicate your pain level on a scale of 0-10 with “0” = no pain and “10” = worst pain imaginable.

**Present Pain**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

**Worst is gets**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

**Most of the time**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

**Best that it gets**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
**History of Present Complaint**

1. Age: _______ Male _______ Female _______

2. Where is your problem located?  Neck ___  Arm ___  Back ___  Hip ___  Leg ___  Other ________

3. How long have you had this problem? ________________________ Since? ___/____/____

4. Briefly, please give details of how this problem originally started:

   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

5. Was this from a work-related injury? No __ Yes __ Is it under workers compensation No __ Yes __

6. Are there any law suits pending or being contemplated related to your problems? Yes__ No __
   If yes, please give your attorney’s name and phone number: _____________________________

7. Please describe your present pain/problem now (what you feel, where, when, etc.):

   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________
   _________________________________

8. Have you had spinal surgery in the past: (Check one) Yes___ No___
   (If no skip question 9)
   How many times? _________________
   What type of surgery(s) was/were performed? Discectomy ___ Laminectomy ___ Fusion___
   Unknown ____ other: __________________________
   What spinal level? ________________ Did you improve from your spine surgery procedure? ________

9. Which of the following best describes your ratio for neck & arm or back & leg discomfort

   A. 100% back pain and 0% leg pain  A. 100% neck pain and 0% arm pain
   B. 75% back pain and 25% leg pain  B. 75% neck pain and 25% arm pain
   C. 50% back pain and 50% leg pain  C. 50% neck pain and 50% arm pain
   D. 25% back pain and 75% leg pain  D. 25% neck pain and 75% arm pain
   E. 0% back pain and 100% leg pain  E. 0% neck pain and 100% arm pain

10. For any pain/numbness in your arm(s) or leg(s), which side is worse? (Choose one if appropriate)

    **Leg Symptoms**
    A. 100% left leg and 0% right leg
    B. 75% left leg and 25% right leg
    C. 50% left leg and 50% right leg
    D. 75% right leg and 25% left leg
    E. 100% right leg and 0% left leg

    **Arm Symptoms**
    A. 100% left arm and 0% right arm
    B. 75% left arm and 25% right arm
    C. 50% left arm and 25% left arm
    D. 75% right arm and 25% left arm
    E. 100% right arm and 0% left arm
11. Please choose letters A – F (in first column) to answer the questions in column two.

A. Unable to tolerate  How long can you sit? ___________________
B. About 15 minutes only
C. About 30 minutes only  How long can you stand? _________________
D. About 45 minutes
E. About 1 hour  How long can you walk? __________________
F. Indefinitely

12. Which of the following activities change the nature of your pain?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Aggravates</th>
<th>Relieves</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Standing</td>
<td>___</td>
<td>___</td>
<td>___</td>
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<tr>
<td>Walking</td>
<td>___</td>
<td>___</td>
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<tr>
<td>Leaning/Bending forward</td>
<td>___</td>
<td>___</td>
<td>___</td>
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<tr>
<td>Lying on your side</td>
<td>___</td>
<td>___</td>
<td>___</td>
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<tr>
<td>Lying on your back</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Lying on your stomach</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Rising from sitting</td>
<td>___</td>
<td>___</td>
<td>___</td>
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<tr>
<td>Changing positions</td>
<td>___</td>
<td>___</td>
<td>___</td>
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<tr>
<td>Coughing/Sneezing</td>
<td>___</td>
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<tr>
<td>Driving</td>
<td>___</td>
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</tbody>
</table>

Now go back and CIRCLE the most aggravating activity and the most relieving activity.

13. If the symptoms of your present pain have changed, please indicate the most appropriate statement: (Circle one)

A. My symptoms have remained the same since the time of onset.
B. My symptoms are more severe since the time at onset.
C. My symptoms are less severe since the time of onset.

14. How have the symptoms of your present pain changed: (Circle one)

A. No change in symptoms.
B. My symptoms have worsened over time.
C. My symptoms have improved over time.
15. Of the following list of treatments, please indicate the effect of those which have been used in an attempt to help your present injury: (Check one of each)

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Which type</th>
<th>Helpful</th>
<th>No Help</th>
<th>Not Used</th>
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</thead>
<tbody>
<tr>
<td>Anti Inflammatory</td>
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<tr>
<td>Muscle Relaxants</td>
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<tr>
<td>Narcotic Pain Medications</td>
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<tr>
<td>Acetaminophen/Tylenol</td>
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<td>Hot Packs</td>
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<tr>
<td>Ice</td>
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<td>TENS Unit / Muscle Stim</td>
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<tr>
<td>Physical Therapy Treatment</td>
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<tr>
<td>Back / Neck Exercises</td>
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<tr>
<td>Chiropractor</td>
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<tr>
<td>Epidural Block / Injection</td>
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<td>Facet Block / Injection</td>
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<td>SI Joint Block / Injection</td>
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<tr>
<td>Trigger Point Injection</td>
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<tr>
<td>Acupuncture</td>
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<tr>
<td>Other: _________________________</td>
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</table>

16. Please indicate whether you have had any of the following studies and write when / where the most recent was:

<table>
<thead>
<tr>
<th>Study</th>
<th>Yes</th>
<th>No</th>
<th>When / Where</th>
<th>Yes</th>
<th>No</th>
<th>When / Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular X-ray</td>
<td></td>
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<td>____________</td>
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<td>____________</td>
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<tr>
<td>CT Scan of Spine</td>
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<tr>
<td>Bone Scan</td>
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<td>____________</td>
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</table>

17. Have you had any past episodes of similar pain or injury? Yes or No (please describe)

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

18. List all other physicians with whom you have consulted in the past year for this problem.

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
19. Current work status: Working full duty __ Working restricted duty __ (Since _____)
   Retired __ Disabled __ (Since__) Student __ Homemaker __ Unemployed __
   Company: _______________________ Occupation: ___________________
   Title: _________________________ How long have you worked for this company? _____________

20. Marital status: Single __ Married __ Divorced __ Widowed __

21. Number of Children: __________

22. I live: Alone __ With: _____________________________________________________________

23. I live in: House ____ Apartment __ Assisted living __ Nursing home __

   If answered “yes” or “quit”, how much do or did you smoke per day?
   Less than ½ pack __ ½ pack __ ¾ pack __ 1 pack More (How many?) __
   How old were you when you started smoking? ________________

25. Do you drink any alcoholic beverages? (Check one)
   None __ 0 to 3 per month __ 1 to 2 drinks per week __ 1 to 2 drinks per day __
   3 to 5 drinks per day __ More than 5 drinks per day. How many? ________
   Alcoholic in past? Yes __ No __

26. Have you ever had a problem with drug dependence? Yes__ No __
   If yes, then: Cocaine __ Heroin __ Marijuana __ Narcotics __ Other: _______________________________

27. Please write any additional information that you feel is important for us to know.

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
Sensory Defects
  Loss of Hearing or Deaf....Yes __ No __
  Loss of Vision or Blind.....Yes __ No __

Respiratory (Lung or Breathing Problems)
  Asthma / Wheezing........Yes __ No __
  Emphysema / COPD.........Yes __ No __
  Lung Disease..............Yes __ No __
  Sleep Apnea................Yes __ No __
  Tuberculosis................Yes __ No __

Cardiac (Heart Problems)
  Heart Attack................Yes __ No __
  Heart Disease...............Yes __ No __
  Heart Failure...............Yes __ No __
  Heart Murmur...............Yes __ No __
  Rheumatic Fever............Yes __ No __
  High Blood Pressure........Yes __ No __
  High Cholesterol...........Yes __ No __

Vascular (Circulation Problems)
  Wounds or Sores............Yes __ No __
  Peripheral Artery Disease...Yes __ No __
  Peripheral Vascular disease..Yes __No __

Gastrointestinal (GI or Abdominal Problems)
  Liver Disease...............Yes __ No __
  Hepatitis...................Yes __ No __
  Gall Bladder Problems.......Yes __ No __
  Crohn’s / UC / IBS...........Yes __ No __
  Ulcers........................Yes __ No __

Renal (Kidney Problems)
  Kidney Failure...............Yes __ No__
  Kidney Disease...............Yes __ No __
  Kidney Stones................Yes __ No __

Musculoskeletal (Bone, Joint, or Muscle Problems)
  Arthritis........................Yes __ No __
  Osteoporosis..................Yes __ No __

Neurological (Brain or Nerve Problems)
  Stroke......................Yes No __
  TIA............................Yes __ No __
  Seizures.....................Yes __ No __
  Headaches / Migraines........Yes __ No __

Mental Health
  Alzheimer’s....................Yes __ No __
  Anxiety......................Yes __ No __
  Dementia.....................Yes __ No __
  Depression...................Yes __ No __
  Mental Illness..............Yes __ No __

Hematologic (Blood Problems)
  Anemia........................Yes __ No __
  Bleeding Disorder............Yes __ No __
  Clotting Problems............Yes __ No __
  Sickle-Cell Disease..........Yes __ No __

Oncologic (Cancer)
  Breast......................Yes __ No __
  Colorectal...................Yes __ No __
  Leukemia.....................Yes __ No __
  Lymphoma.....................Yes __ No __
  Prostate......................Yes __ No __
  Urinary / Bladder.............Yes __ No __
  Chemotherapy................Yes __ No __
  Radiation Therapy...........Yes __ No __

Other Medical Illnesses (please list)

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Immunologic / Infectious Disease
  Aids............................Yes __ No __
  HIV.........................Yes __ No __
  Auto-immune................Yes __ No __

Endocrine
  Diabetes.....................Yes __ No __
  Low Blood Sugar............Yes __ No __
  Thyroid Problems...........Yes __ No __
**OTHER SURGICAL / MEDICAL HISTORY**

Have you had any of the following implants?  
Yes ___ No ___  

- Implantable Cardioverter – Defibrillator  
  Yes ___ No ___  
- Pacemaker  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Spinal Cord Stimulator  
  Yes ___ No ___ (date) ___ / ___ / ___  

Have you had any of the following operations? Yes ___ No ___  

- Appendix  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Mastectomy  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Brain (date)  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Prostate Removal  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Gall Bladder  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Spine / Joint  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Heart  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Thyroid  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Hernia (date)  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Tonsils  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Hysterectomy  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Other (specify)  
  Yes ___ No ___ (date) ___ / ___ / ___  

Have you had any of the following transplants? Yes ___ No ___  

- Heart  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Lung  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Kidney  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Pancreas  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Liver  
  Yes ___ No ___ (date) ___ / ___ / ___  
- Other (specify)  
  Yes ___ No ___ (date) ___ / ___ / ___  

Have you or your family ever had any complications due to dye or contrast? Yes ___ No ___  

Have you had any previous non-surgical hospitalization(s)? (please use last page for additional space)  

<table>
<thead>
<tr>
<th>Reason for Hospitalization</th>
<th>Date</th>
<th>Hospital Name</th>
<th>Any Complications?</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**FAMILY MEDICAL HISTORY**

Please indicate whether any of your BLOOD RELATIVES have had any of the medical illnesses listed below  

<table>
<thead>
<tr>
<th></th>
<th>Mother</th>
<th>Father</th>
<th>Grandparent</th>
<th>Sibling</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td></td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Cardiovascular</td>
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<tr>
<td>Heart Attack</td>
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<tr>
<td>Heart Disease</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Endocrine</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Low Blood Sugar</td>
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<td>Thyroid Disease</td>
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<td>Neurological</td>
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<td>Stroke</td>
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<tr>
<td>Mental Health</td>
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<td>Alzheimer’s</td>
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<td>Dementia</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Dementia</td>
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<td>Mental Illness</td>
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<td>Oncologic</td>
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<tr>
<td>Cancer</td>
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</tbody>
</table>
Please list all current medications that you are taking below.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Reason Prescribed</th>
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<tbody>
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**ALLERGENS**

Please list all allergies that you have below.

<table>
<thead>
<tr>
<th>SUBSTANCE</th>
<th>REACTION</th>
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<tbody>
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</table>
Authorization for Release of Medical Records (To obtain records from another Professional Medical Facility)

I, __________________________, authorize that my recent medical records be released to:

   Person Authorizing Release

   Colquitt Regional Medical Center
   Pain Management Services
   P.O. Box 40
   Moultrie, Ga 31776

Please list the name of the physician(s) who referred you to us or any physician, person(s), business(s) you would allow us to request or release your personal Health information.

To: __________________________________________________________ (primary care physician)
   __________________________________________________________ (referring physician)
   __________________________________________________________ (other physician)
   __________________________________________________________ (significant other)
   __________________________________________________________ (attorney/case manager)
   __________________________________________________________ (other care takers)

I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows records at be mailed or faxed. I understand that I may revoke this consent at anytime. This consent will automatically expire without my expressed revocation 1 year from the date on this form.

____________________________________________________________________________
Patient Last Name First Name MI
____________________________________________________________________________
Address
____________________________________________________________________________
City State Zip
____________________________________________________________________________
Patient’s Date of Birth SSN
____________________________________________________________________________
Patient/Guardian Signature