CAUSEWAY INTERVENTIONAL MEDICINE, LLC
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INITIAL VISIT PATIENT PACKET

(Please Print)

DATE:_____ SS#: _____

Patient Name LAST: _____ First: _____

Home Phone/Cell Phone _____

Address: _____ City:_____ STATE _____ ZIP _____

DOB _____ SEX: _____ Referred by: _____

Education: _____ Occupation (s) _____

Type of Work: _____ Full/Part Time (circle one) Disability: Yes__ No__ Pending __

Emergency Contact: _____ Phone _____

Are you receiving or expecting to receive Worker's Compensation? Yes ___ No ___ check one

Are you presently involved in a law suit? Yes _____ No _____ If Yes, please explain: _____
_____

Check all that apply to your symptoms:
Work related: ( ) Recurrence of Previous injury ( ) Motor Vehicle accident ( )
Athletic/recreational injury ( ) Other (specify): _____

Name and location of facility(s) where X-Ray/MRI(s) were performed:
_____
_____
_____
_____

Name and location of medical providers and/or facilities were previous relevant treatments were provided:
_____
_____
_____

Name of dispensing pharmacies starting with the immediate past:
_____
_____

PATIENT SIGNATURE/DATE: _____

Causeway Interventional Medicine LLC

YOUR PAINFUL MEDICAL PROBLEMS

Why did you come see us today?

_____
_____
_____
_____
_____

Where do you have pain and how intense is the range from best to worse without treatment?

Where:		Intensity	Best	Worst	Typical Pain	Electricity
Head	_____	(1-10):	_____	_____	_____	_____
Neck	_____		_____	_____	_____	_____
Upper back	_____		_____	_____	_____	_____
Lower back	_____		_____	_____	_____	_____
Tailbone/Pelvis	_____		_____	_____	_____	_____
Abdomen	_____		_____	_____	_____	_____
Arm	_____		_____	_____	_____	_____
Leg	_____		_____	_____	_____	_____

What caused your current painful condition?

Normal Activity	_____
Motor Vehicle accident	_____
Sports or recreation	_____
Fall	_____
Job related	_____
Cancer or illness	_____

Check the following that describe your pain

__ Dull/aching	__ Cramping	__ Squeezing
__ Hot/Burning	__ Numbness	__ Tingling
__ Shooting	__ Spasms	__Stabbing
__ Throbbing	__ Tightness	__ Sharp
__Pins + Needles	__ Hypersensitive	__ Intractable
__ Intermittent	__ Affected by weather	

Describe the circumstances:

_____
_____
_____
_____
_____
_____
_____

What are your diagnoses?

_____
_____
_____
_____
_____
_____
_____

Patient signature/date: _____ Physician signature/date: _____

Causeway Interventional Medicine LLC

Mark what changes your pain level:

	Increases	Decreases
Bending backward	_____	_____
Bending forward	_____	_____
Changes in weather	_____	_____
Climbing stairs	_____	_____
Driving	_____	_____
Lifting objects	_____	_____
Coughing/sneezing	_____	_____
Looking upwards	_____	_____
Looking downwards	_____	_____
Rising from seated position	_____	_____
Sitting	_____	_____
Standing	_____	_____
Walking	_____	_____
Other: _____	_____	_____

Associated symptoms and issues (circle):

Numbness/Tingling
Balance problems
Weakness in arm/leg/other
Bladder incontinence
Bowel incontinence
Joint swelling/stiffness
Fever/chills
Nausea
Sleep
Appetite
Physical Activity
Relationships (irritablility)
Emotions (anger, suicidal, crying, withdrawal, depression)
Concentration
Sexual function
Other: _____

How much does your pain limit you in your:

	None	A little	Moderate	A great deal
Work	_____	_____	_____	_____
Activities of daily living	_____	_____	_____	_____
Socialization	_____	_____	_____	_____
Recreation	_____	_____	_____	_____
General enjoyment	_____	_____	_____	_____

Patient signature: _____ Date: _____
Physician's signature: _____ Date: _____