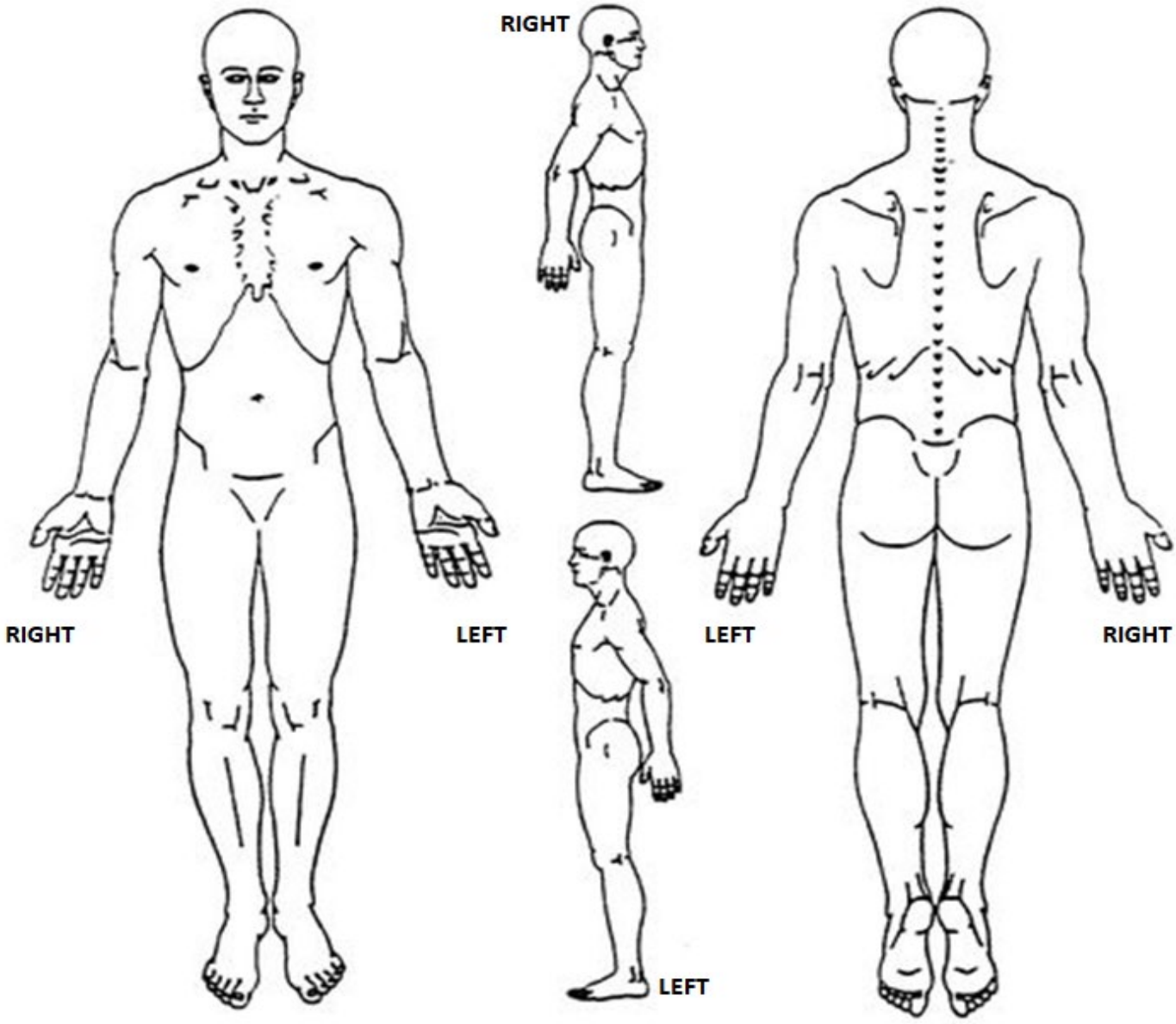
NEUROVERSION
Break the cycle of pain

New Patient Medical Summary
Pain, other (hyperhidrosis)

Name: _____ DOB: _____

Chief complaint(s): _____

Using the diagram below, please mark the location(s) of your pain and/or condition:



When did your pain begin? Date: _____ **OR** _____ DAYS _____ MONTHS _____ YEARS

How did your pain begin?

□ Injury at work
□ Injury not at work
□ Motor vehicle accident
□ Illness
□ Surgery
□ Due to other medical treatment

□ Other _____

What words best describe your pain?

□ Burning	□ Sharp	□ Throbbing	□ Cutting
□ Aching	□ Soreness	□ Dull	□ Pins and needles
□ Cramping	□ Shooting	□ Pressure	

□ Other _____

□ Other _____

Does your pain radiate anywhere: □ Yes □ No

If YES, please explain where: _____

My average pain level is (circle one): 1 2 3 4 5 6 7 8 9 /10

How often do you have pain (Please check one):
□ Constantly (100% of the time)
□ Nearly constantly (60-95% of the time)
□ Intermittently (30-60% of the time)
□ Occasionally (less than 30% of the time)

When do you feel your pain is most persistent (Select all that may apply):
□ Morning □ Midday □ Afternoon □ Evening □ Night

What do you associate your pain with or does your pain influence/cause:

□ Anger	□ Headache	□ Numbness
□ Anxiety	□ Incontinence	□ Poor sleep
□ Blurred vision	□ No bowel function	□ Sexual dysfunction
□ Change in appetite	□ Bladder dysfunction	□ Sleep apnea
□ Fatigue	□ Nocturnal movements	□ Weakness

What makes your pain better?

□ Sleeping	□ Exercise	□ Injections	□ Ice	□ Physical therapy
□ Lying down	□ Heat	□ Medication	□ Rest	

□ Other _____

□ Other _____

What makes your pain worse?

□ None	□ Lifting	□ Standing	□ Sitting	□ Climbing stairs
□ Sleeping	□ Walking	□ Straining	□ Driving	□ Bending

□ Other _____

□ Other _____

□ Other _____

□ Other _____

What medications have you tried? If you run out of room, please provide a separate list.

Medication Name	Side Effects (if any)	Effectiveness		
□ Tylenol with Codeine #3 or #4, Fiorecet with Codeine, or Codeine		□ Worse	□ No change	□ Improved
□ Hydrocodone, Norco/Vicodin		□ Worse	□ No change	□ Improved
□ Hydromorphone/Dilaudid		□ Worse	□ No change	□ Improved
□ Methadone		□ Worse	□ No change	□ Improved
□ Buprenorphine/Butrans/ Belbuca/Suboxone/Zubsolve		□ Worse	□ No change	□ Improved
□ Tramadol or Ultram		□ Worse	□ No change	□ Improved
□ Oxycodone, Oxycontin, Percocet or Roxycodone		□ Worse	□ No change	□ Improved
□ Fentanyl/Duragesic/ Sublimaze		□ Worse	□ No change	□ Improved
□ Morphine/Duramorph or MS Contin		□ Worse	□ No change	□ Improved
□ Nucynta		□ Worse	□ No change	□ Improved
□ Cymbalta/Duloxetine		□ Worse	□ No change	□ Improved
□ Lyrica/Pregablin		□ Worse	□ No change	□ Improved
□ Gralise		□ Worse	□ No change	□ Improved
□ Gabapentin/Neurontin		□ Worse	□ No change	□ Improved
□ Topamax/Topiramate		□ Worse	□ No change	□ Improved
□ NSAIDS: Aspirin, Ibuprofen Naproxen, Celecoxib, etc.		□ Worse	□ No change	□ Improved
□ Baclofen		□ Worse	□ No change	□ Improved
□ Flexeril/Cyclobenzaprine		□ Worse	□ No change	□ Improved
□ Tizandine/Zanaflex		□ Worse	□ No change	□ Improved
□ Robaxin/Methocarbamol		□ Worse	□ No change	□ Improved
□ Other _____		□ Worse	□ No change	□ Improved
□ Other _____		□ Worse	□ No change	□ Improved
□ Other _____		□ Worse	□ No change	□ Improved
□ Other _____		□ Worse	□ No change	□ Improved

Does your *current* medication regimen provide improvement of daily activities/function? □ Yes □ No
If YES, please list activities/functions you are able to perform with your *current* medication regimen:

Have you had issues with medication regimen compliance? □ Yes □ No

If YES, please explain why:

What non-pharmacologic approaches have you tried? Complete following:

Therapy Type	Date(s) Tried (if known)	Effectiveness		
□ Physical therapy		□ Worse	□ No change	□ Improved
□ Occupational therapy		□ Worse	□ No change	□ Improved
□ Aquatic therapy		□ Worse	□ No change	□ Improved
□ Massage therapy		□ Worse	□ No change	□ Improved
□ Manual therapy		□ Worse	□ No change	□ Improved
□ Chiropractic adjustments		□ Worse	□ No change	□ Improved
□ TENS unit		□ Worse	□ No change	□ Improved
□ Procedures		□ Worse	□ No change	□ Improved
□ Biofeedback		□ Worse	□ No change	□ Improved
□ Acupuncture		□ Worse	□ No change	□ Improved
□ Psychotherapy		□ Worse	□ No change	□ Improved
□ Other		□ Worse	□ No change	□ Improved
□ Other		□ Worse	□ No change	□ Improved

What specialists have you seen for your *current* condition, please provide their names if known:

Specialty	Provider Name and/or Facility	Date of Last Visit/Consultation (if known)
□ Primary care physician		
□ Neurologist		
□ Physiatrist		
□ Neurosurgeon		

□ Orthopedic surgeon		
□ Other		
□ Other		
□ Other		
□ Other		
□ Other		

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Do you have a family history of alcohol abuse?	□ Yes	□ No
Do you have a family history of illegal drug abuse?	□ Yes	□ No
Do you have a family history of prescription drug abuse?	□ Yes	□ No
Do you have a personal history of alcohol abuse?	□ Yes	□ No
Do you have a personal history of illegal drug abuse?	□ Yes	□ No
Do you have a personal history of prescription drug abuse?	□ Yes	□ No
Are you between the ages of 16-45?	□ Yes	□ No
Do you have a history of preadolescent sexual abuse?	□ Yes	□ No
Do you have ADD, OCD, bipolar, or schizophrenia?	□ Yes	□ No
Do you have history or are currently depressed?	□ Yes	□ No

Have you used drugs other than those for medical reasons in the past 12 months? □ Yes □ No

If YES, please explain why: _____

Have you ever been in a detoxification program for drug abuse? □ Yes □ No

Have you attended Narcotics Anonymous? □ Yes □ No

To the fullest of my knowledge, I have accurately and truthfully completed my health history.

Signature: _____ Date: _____