Pain Management-Psychological Assessment-Hypnotherapy-Biofeedback-Cognitive Behavioral Therapy

Don Goodman, Ph.D., C.C.Ht.
Clinical Psychologist
Lic. #PSY 22613

270 26 th St Suite 202
Santa Monica CA 90402
(818) 917-4524 (Cell)

UCLA

101 Hodencamp Rd. Suite 114
Thousand Oaks CA 91362
Drdgoodman1@verizon.net (Email)

PERSONAL INJURY / ACCIDENT MEDICAL HISTORY INTAKE FORM

(Mark a ✓ on each that applies)

Referred by: ____________________ Account No.: __________ Date: __________

Full Name: ____

Gender: ☐M ☐F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Age: ________

Birth Date: ___/____/____ Height ________ Weight __________

Address: ____

City: ______________________________ State: ________ Zip: __________

Social Security No.: ________-______-________ Driver's License No.:________________

Home Phone: (____) ____________________ Cellular Phone.: ____________________

Employer: ____

E-Mail: __________________________ Work Phone: (_____) ______________

Employer Address: ____

****

INSURANCE / ATTORNEY INFORMATION:

Insured's Name: ____
(Last) (First) (Init)

Relation to patient: __________ D.O.B.: _________ Soc. Sec. #: ____________

Insurance Company: ____

ID#: __________________________ Group #: ____________________

Do you have MedPay? ☐Yes ☐No Were you at fault? ☐ Yes ☐ No

Insurance Company of the Person at Fault: ______________________________

Insurance Company Address: ______________________________________

City: ______________________________ State: ________ Zip: ________

* *

Have you retained an attorney? Yes / No

Your Attorney's Name: ____

Your Attorney's Phone: (_____) __________________ Fax (_____) __________________

Your Attorney's Address: ____

City: ______________________________ State: _______ Zip: ________

ACCIDENT INFORMATION:

Date of Accident: ________/________/________ Time of Accident: ____________ a.m. / p.m.

Your Vehicle: Year _____________ Make ______________________ Model______________________

Other Vehicle: Year _____________ Make ______________________ Model______________________

Seat Belt: ☐ Yes ☐ No Accident Type: ☐Rear ended ☐Head-on ☐Broad-sided

Damage to Your Vehicle: $ __________________ Other Vehicle Damage: $ __________________

Describe Accident: ____

____

ACCIDENT SPECIFICS: (Mark a ✓ on each that applies to the accident)

Was this injury accident related? ☐ Yes ☐ No ☐ Auto ☐ Work ☐ Other

Was this a Job or Work related injury: ☐ Yes ☐ No Were you the: ☐ Driver ☐ Passenger

If passenger, where were you sitting: ☐ Front Seat ☐ Back Seat

Were you wearing your seatbelt: ☐ Yes ☐ No Did the airbag deploy: ☐ Yes ☐No

Impending Collision, were you: ☐ Aware ☐ Unaware ☐ Braced ☐ Not braced

Did your head: ☐ Strike Object ☐ Not strike Object ☐ Break Glass ☐ Other

Did you experience: ☐Shock ☐Loss of Consciousness ☐Whiplash ☐ Other

The Weather Conditions were they: ☐ Sunny ☐ Raining ☐ Snowing ☐ Foggy

The Road was: ☐ Dry ☐ Wet ☐ Icy Time of Day: ☐ Dawn ☐ Day ☐Dusk ☐ Night

State your emotions and physical state immediately following the accident: _________________________

____

State your emotions & physical state after the first few days: ______________________________________

____

IMMEDIATELY FOLLOWING THE ACCIDENT: (Mark a ✓ on each that applies to the accident)

☐Ambulance / Paramedics were called
☐I was transported to Hospital by Ambulance
☐I was diagnosed at the Hospital
☐Medication was prescribed
☐I was treated at the scene
☐I went to Hospital in my own
☐I was treated at the Hospital
☐Follow-up was recommended

OTHER DOCTORS SEEN:

☐Orthopedist ☐Neurologist ☐Psychiatrist ☐Physiatrist ☐Chiropractor
☐Acupuncturist ☐General Practitioner ☐Physical Therapist ☐Massage Therapist
☐Other

SYMPTOMATOLOGY: (Pain characteristics for major area of complaint)

The pain started: ____

____

The pain is made better by: ____

____

and worse by____

____

The pain has the following qualities: ____

____

There is / There isn't radiation into: ____

____

There is / There isn't referred pain into: ____

____

There is / There isn't parentheses (tingling/numbness) into: _____________________________

____

The pain is located: ____

____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.):__________________

____

DAILY ACTIVITIES:

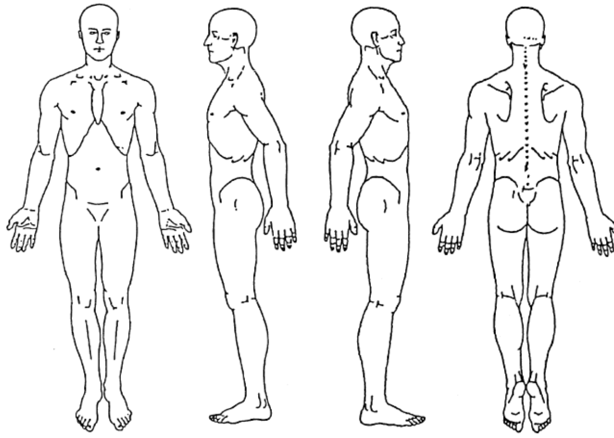
How many days out of an average week do you have pain? ☐ >1 ☐ 2-5 ☐ 5-7
How much time out of an average day are you in pain? ☐ Always ☐ Sometimes ☐ Never
What are the worst times of day for the pain? ☐ Morning ☐ Noon ☐ Evening ☐ Other
When do you feel the best? ☐ Morning ☐ Noon ☐ Evening ☐ Other

PAIN RATING:

On a scale of 0 – 10, rate your pain: (Please ○ the number that best describes your pain)

No Pain Severe Pain
0 1 2 3 4 5 6 7 8 9 10

Please use the legend symbols below to accurately mark the areas in which you feel these sensations:
Stabbing/Cutting-//// Tingling-* * * * Burning-XXXX Cramping- ^^^^
Numbness-NNNN Dull-####



Describe the overall severity of the pain:

☐ Mild Nuisance ☐ Mild to moderate, but can live with it

☐ Moderate, having trouble coping with it ☐ Severe, it is ruining my quality of life

How do the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	☐	☐	☐	________
Walking	☐	☐	☐	________
Standing	☐	☐	☐	________
Lying Down	☐	☐	☐	________
Looking up	☐	☐	☐	________
Looking Down	☐	☐	☐	________
Lifting	☐	☐	☐	________

PROGRESSION:

How is your pain compared to when the pain episode first started?

☐ Much Improved ☐ Somewhat Improved ☐ Much Worse ☐ Somewhat Worse ☐ No Change

What do you do to relieve the pain? ____

____

____

Please mark a ✓ on each that applies to your daily activities:

☐ Have difficulty climbing stairs.

☐ Have to use handrails to get up stairs, etc.

☐ Have to hold onto something to sit or stand from a chair.

☐ Stay at home most of the time.

- ☐ Do not do jobs around the house.
- ☐ Walk slower than usual.
- ☐ Can only walk short distances.
- ☐ Have to sit most of the day.
- ☐ Can only stand for short periods of time.
- ☐ Stays in bed most of the day.
- ☐ Change position frequently to try and get comfortable.
- ☐ Have difficulty turning over in bed.
- ☐ Have to lie down and rest frequently.
- ☐ Have difficulty sleeping.
- ☐ Have to get other people to do things for me.
- ☐ Have difficulty getting dressed.
- ☐ Have to get dressed with someone's help.
- ☐ Have difficulty bending or kneeling.
- ☐ Have a loss of appetite.
- ☐ Have more irritable stages.

What are some recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent as before? ____

____

____

____

How often do you have to stop activities and sit or lie down to control your symptoms?

☐ Several Times ☐ Occasionally ☐ Approximately _____ per day ☐ Never ☐ All Day

List your hobbies & exercise activities ____

____

____

SOCIAL HISTORY:

☐ Smoker ☐ Non-Smoker ☐ Do not drink alcohol ☐ Drink alcohol

How much? ___________ How often? ___________

☐ Do not take drugs ☐ Take Drugs How much? ___________ How often? ___________

Number of Children: ___________

MEDICAL HISTORY:

List any medical professionals you have seen for this problem: ____

____

List any medications you are currently taking: ____

____

List the treatments you have had for your problem:

☐ Chiropractic ☐ Osteopathy ☐ Trigger Point Injections ☐ Epidural Injections
☐ Acupuncture ☐ Naturopathy ☐ Hot packs ☐ Ultrasound ☐ Diathermy ☐ Massage
☐ Electrical Stimulation ☐ Biofeedback ☐ TENS Unit ☐ Body Mechanics Training
☐ Strengthening Exercises ☐ Aerobics ☐ Gravity Inversion / Traction ☐ Bed Rest
☐ Back Brace ☐ Other: ______________________

List the types of Diagnostic Testing that has been performed for this problem:

☐ X-Rays ☐ C.T. Scan ☐ Myelogram ☐ M.R.I. Scan ☐ Discogram ☐ Bone Scan
☐ E.M.G. ☐ N.C.S.

List Past Surgeries: ☐ None

____

____

List Past Hospitalizations: ☐ None

____

____

List previous back, neck and musculoskeletal problems: ____________________________________

____

____

MEDICAL HISTORY:

Please mark a ✓ if you have had any of the following symptoms in the past 5 years.

☐ Unexplained fevers ☐ Night sweats ☐ Weight loss of 10 lbs or more ☐ Loss of appetite
☐ Excessive fatigue ☐ Depression ☐ Difficulty sleeping ☐ Unusual stress at work
☐ Unusual stress at home ☐ Easy bruising ☐ Excessive bleeding ☐ Swollen ankles
☐ Lumps in neck, armpit or groin ☐ Chest pain or tightness ☐ Trouble breathing with exercise
☐ Trouble breathing lying flat ☐ Coughing up blood ☐ Stomach pain ☐ Persistent diarrhea
☐ Change in bowel habits ☐ Excessive constipation ☐ Dark black stools ☐ Blood in stools
☐ Pain when urinating ☐ Burning when urinating ☐ Difficulty urinating ☐ Blood in urine
☐ Urinating more at night ☐ Abnormal vaginal bleeding ☐ Morning stiffness ☐ Skin rashes
☐ Muscle tenderness ☐ Persistent eye redness ☐ Persistent or unusual cough ☐ Joint pain
☐ Dry eyes ☐ Dry mouth ☐ Swelling

Do you have any current problems with:

☐ Anxiety ☐ Depression ☐ Irritability ☐ Other: ________________________

Do you have a home exercise program that you follow on a regular basis?
☐ Yes ☐ No

NOTES:

____

____

____

____

____ ______________________
Signature Date