THOMAS SYNEK M.D.

Pain Management - Physical Medicine & Rehabilitation

Today's Date: _____ *EMAIL: _____
Patient Name: _____ SSN: _____-_____-_____
Date of Birth: _____
Height: _____Weight: _____ Sex: Male Female Marital Status M___S___D___L___W___
Home Phone (____) _____ Cell # (____) _____
Mailing Address_____ City _____ State_____ Zip_____
Employer Name/Address_____ WK # (____) _____
Emergency Contact _____Phone # (____) _____ Relationship _____
Primary Insurance _____Phone# (____) _____ ID # _____ Group # _____
Subscriber Name _____ Subscriber DOB ____/___/___
Secondary Insurance _____ Phone# (____) _____ ID# _____ Group # _____
Subscriber Name _____ Subscriber DOB ___/___/___
Pharmacy Name _____ Phone # (____) _____ Location _____
Primary Care Physician: _____ Referring Physician _____

If you would like to designate someone access to your records, please fill out the following:

I designate, _____, to access and inquire about my protected medical information.

Individual listed is: _____
Relationship to Patient

Chief Complaint (Why are you here today, or where do you have pain): _____
_____

History of Pain:
Date of Injury: _____
Compensable Area (if workers compensation): _____
Brief Description of how you were injured: _____

History of Present Illness:

How would you describe your pain? **Circle one or more**: burning, shooting, aching, stabbing, sharp, dull, throbbing, cramping, crushing, vague, tingling, stiff, tight, heavy, sore, nagging, pins and needles,
other: _____

Do you have any of the following symptoms? **CIRCLE one or more**: weakness, spasms, numbness, swelling, headaches, hot, cold, other: _____

Frequency? ☐ frequent ☐ constant ☐ occasional

Does the pain keep you from falling asleep? YES NO
Does the pain wake you up at night? YES NO
Do you get poor sleep for other reasons besides pain? YES NO What are the reasons? _____

What makes the **pain BETTER?** _____
What makes the **pain WORSE?** _____

Name: _____
DOB: _____

What have you done to treat the pain? **Circle one or more:** Heat, cold, medications, acupuncture, physical therapy, aqua therapy, home exercises, TENS unit, injections, surgery, chiropractor, other: _____

What is your pain like **CURRENTLY** on a scale from 0-10? 0-1-2-3-4-5-6-7-8-9-10

What is your pain like at its **BEST** (with medications etc.)? 0-1-2-3-4-5-6-7-8-9-10

What is your pain like at its **WORST?** 0-1-2-3-4-5-6-7-8-9-10

Do you have any side effects with your current medications? _____
_____

Do you have any problems with bowel or bladder dysfunctions (incontinence, constipation…)? _____
_____

ADL Assessment

Rate difficulty of
Performing the following:

0-5 rating
0- no difficulty
5- unable to perform alone

Eating 0 1 2 3 4 5

Bathing	0 1 2 3 4 5
Using toilet	0 1 2 3 4 5
Dressing	0 1 2 3 4 5
Getting up from bed/chair	0 1 2 3 4 5

Name: _____
DOB: _____

PAST HISTORY

Past Medical History (High blood pressure, diabetes, asthma, etc)**:** _____
_____
_____
_____
_____
_____
_____

Past Surgical History (Surgery and Date): _____
_____
_____
_____
_____
_____

Have you had any problems with anesthesia Yes ___ No ___, explain _____
_____

Past Psychiatric History (Depression, Anxiety, Bipolar, Disorder, etc): _____
_____
_____
_____

Previous Pain Treatment (Procedure, Date, and Physician): _____
_____
_____
_____

Social History:

Do you smoke? YES NO

How much do you smoke on average (packs/day)? _____

Date if you quit_____

Do you use any other tobacco products? YES NO

Do you use alcohol? YES NO rarely occasionally heavy quit (date)_____

Do you use any illicit drugs? YES NO _____

Current Occupation (previous if not working): _____

Current Job Status: employed full-time employed part-time retired unemployed

Are you on disability? YES NO

Any ongoing litigation? YES NO

Name: _____
DOB: _____

REVIEW OF SYSTEM

Please answer the below questions to the best of your ability. Please feel free to write comments as needed. I will use this to improve your care and for dictation of your initial consult.

General
☐ Trouble Sleeping
☐ Chills
☐ Fatigue
☐ Weight gain
☐ Weight loss

Eyes
☐ Glasses or contacts
☐ Blind spots
☐ Blurred Vison
☐ Discharge
☐ Eye Pain

Ears, Nose, Mouth, Throat
☐ Ringing ears
☐ Decrease Hearing
☐ Ear pain
☐ Nose bleeding
☐ Sinus Pain
☐ Sore throat
☐ Drainage
☐ Discharge

Endocrine
☐Cold intolerance
☐ Excessive Sweating
☐ Excessive Thirst
☐ Heat Intolerance
☐ Change in appetite

Respiratory
☐ Cough
☐ Shortness of breath
☐ SOB at rest
☐ SOB at exertion
☐ Sputum Production
☐ Wheezing

Cardiovascular
☐ Leg Cramping
☐ Chest pain at rest
☐ Chest pain with exertion
☐ Arrythmias
☐ Palpitations
☐ Swelling in hands/feet

Gastrointestinal
☐ Abdominal pain
☐ Constipation
☐ Diarrhea
☐ Difficulty Swallowing
☐ Heart burn
☐ Nausea
☐ Vomiting

Hematologic/Lymphatic
☐ Bleeding
☐ Easy bruising
☐ Recent/history of transfusion
☐ Swollen glands
☐ Lymph node tenderness
☐ Warfarin Treatment

Genitourinary
☐ Urgency
☐ Blood in urine
☐ Difficulty urinating
☐ Painful urinating
☐ Change in urinary strength
☐ Incontinence

Musculoskeletal

☐ Redness of joints
☐ Limitation of motion
☐ Atrophy
☐ Stiffness
☐ Arthritis
☐ Joint stiffness
☐ Muscles aches
☐ Swollen joints
☐ Muscle tightness

Neurological

☐ Head injury
☐ Dizziness
☐ Fainting
☐ Headaches
☐ Loss of strength
☐ Seizures
☐ Tingling
☐ Tremor

Psychiatric

☐ Memory loss
☐ Stress
☐ Nervousness
☐ Anxiety
☐ Hallucinations
☐ Depressed moods
☐ Suicidal Ideation

Additional comments: _____

Name: _____
DOB: _____

MEDICATION

Allergies:

Are you allergic to anything? YES NO
Please list all **ALLERGIES** and describe your reaction:

_____
_____
_____
_____

Medications:

List any medications you are taking for pain (include dose and frequency). Please include prescription medications, over the counter medications, and herbal remedies.

Are you currently taking anti-coagulants or blood thinners, such as Coumadin, Aspirin, Plavix, Ticlid, anti-inflammatories or any others? Yes ____ No _____Please circle above or list here

_____

Name of Medication Dose How often taken Reason for taking Length of time taken

_____
_____
_____
_____
_____

_____

_____

_____

_____

Pharmacy Name _____

Phone ( ) _____ Location _____

I consent to the collection and assessment of information needed to develop a multidisciplinary approach to treatment.

I authorize the doctor or insurance company to release any information required for claims. I authorize my insurance benefits to be paid directly to Thomas Synek M.D. I understand that even though I have assigned benefits to be paid directly to the physician, I am still responsible for the entire bill.

Signature _____ Date ____/____/____