Southern Pain and Rehab, LLC **Michael J. Kohrman MD** www.southernpainandrehab.com
Board Certified Physical Medicine & Rehabilitation
EMG/NCV's, IME's, Interventional Pain, Non-Surgical Spine, Sport, Shoulders, Hips, Knees & more
Hours by Appointment
26211 Equity Drive, Suite A Daphne, Alabama 36526-6189 Phone: 251-626-0901 Fax: 251-626-0902

Name ______ **Claim #** ______ **Date** ______

DOB ______ **SSN XXX-XX-** ______ ☐ **Initial Evaluation** ☐ **Follow Up**

Age ☐☐☐ ***Race*** ______ ☐ ***Male*** ☐ ***Female*** ☐ ***Transgender*** ☐ RT ☐ Lft ***Handed***

This problem is ☐ Work Related ☐ Personal Injury ☐ Motor Vehicle Accident *An Attorney is working on this case* ☐ No ☐ Yes

Onset Date ☐ *On* ☐ *Somewhere around* *Day* ☐☐ *Month* ☐☐ *Year* ☐☐☐☐ *Onset was* ☐ Sudden ☐ Gradual

How are you doing ☐ Functional ☐ Dysfunctional ☐ Better ☐ NML ☐ Same ☐ MMI ☐ Worse ☐ Deteriorating ☐ Depressed/Suicidal

Work Status ☐ N/A ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled ☐ Working ☐ Part Time ☐ Restrictions ______

Main Complaint ☐ Pain ☐ Weakness ☐ Numbness ☐ Instability ☐ In-Coordination ☐ Confusion ☐ Balance ☐ Swelling ☐ Emotions

Or? ______

What's Happened? ______

______

______

______

What Helps? ______

What Aggravates it? ______

Recent Tests & Results? ______

______

Had Therapy? ☐ No ☐ Yes ☐ Helped ☐ Same ☐ Worse ***TENS Unit?*** ☐ No ☐ Yes ☐ Helped ☐ Same ☐ Worse

Manipulation ? ☐ No ☐ Yes ☐ Helped ☐ Same ☐ Worse ***Procedure-s ?*** ☐ No ☐ Yes ☐ Helped ☐ Same ☐ Worse

Recent Procedure-s ______

Recent Medical Changes ☐ No ☐ Yes ______

Recent Surgical Changes ☐ No ☐ Yes ______

Energy Level ☐ OK ☐ Chronic Fatigue ☐ Disturbed Sleep ☐ Snores ☐ Naps ☐ Sleep Apnea ***Uses*** ☐ CPAP ☐ BIPAP ☐ Oxygen

Sexual Concerns ☐ N/A ☐ No ☐ Yes ***Issues*** ☐ No Desire ☐ Physical ☐ Emotional ☐ Impotency ☐ Pain ______

Diet Change ☐ No ☐ Yes ***Diet*** ______ ***Allergy Changes*** ______

Pain Medications ☐ No ☐ Yes ☐ Helps ☐ Same ☐ Worse ***Side Effects*** ______

In the Past 3 Months Who Prescribed Pain Medications for you? ______

Still Using ☐ Tobacco ☐ Nicotine ☐ Caffeine ☐ Alcohol ☐ Illegal Drugs ☐ Others Meds ***Has History of*** ☐ Alcoholism ☐ Drug Abuse

ROS: Do you have any NEW problems with any of the following? ☐ No ☐ Yes ***Please Mark the NEW PROBLEMS that apply below***

☐ Fever /Chills ☐ Night sweats ☐ Infections ☐ Cold / Flu ☐ Weight Gain ☐ Weight Loss ☐ Bleeding ☐ Bruising ☐ Clotting

☐ Limb Swelling ☐ Head ☐ Eyes ☐ Ears ☐ Nose ☐ Mouth ☐ Neck / Throat ☐ Chest ☐ Ribs ☐ Abdomen ☐ Pelvis ☐ Groin

☐ Heart ☐ Lungs ☐ Esophagus ☐ Stomach ☐ GI Tract ☐ Liver ☐ Gallbladder ☐ Pancreases ☐ Intestines ☐ Colon ☐ Rectum

☐ Breasts ☐ Female Organs ☐ Male Organs ☐ Kidney ☐ Bladder ☐ Ureters ☐ Hormones ☐ Skin ☐ Nerves ☐ Muscles ☐ Bones

☐ Joints ☐ Tendons ☐ Ligaments ☐ Blood Vessels ☐ Blood Pressure ☐ Thinking /Memory ☐ Emotions ☐ Family ☐ Friends ☐ Work

What ______

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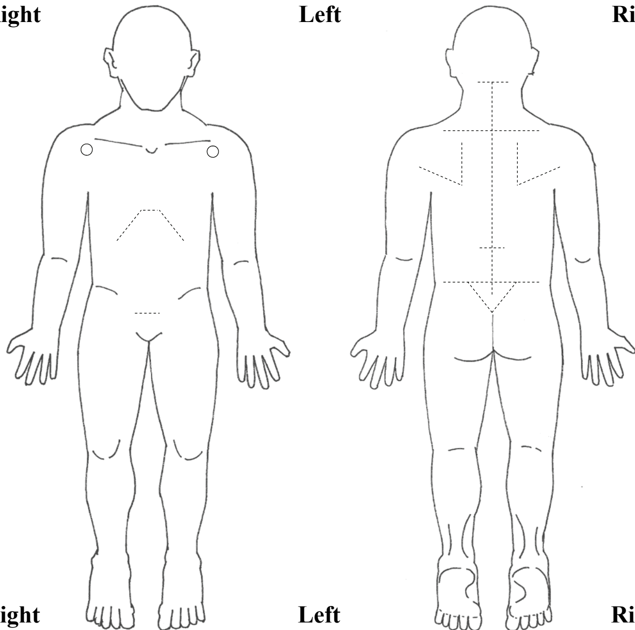
Name **Date**

DOB ____________ **SSN** **XXX-XX** ____________ **INTAKE** ***Please fill in ALL that applies.***

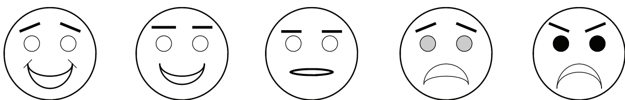
Problems with	Pain Quality	Pain Quality	Pain Intensity	Pain Occurs	Pain Occurs	Duration	Your Sleep is
☐ Pain	☐ Throbbing	☐ Aching	☐ No Pain	☐ Rarely	☐ Morning	☐ Seconds	☐ OK to Good
☐ Numbness	☐ Shooting	☐ Tender	☐ Mild	☐ Occasional	☐ Lunchtime	☐ Minutes	☐ Poor to Bad
☐ Weakness	☐ Stabbing	☐ Splitting	☐ Moderate	☐ Sometimes	☐ Afternoon	☐ Hours	☐ Snores & Naps
☐ Thinking	☐ Sharp	☐ Exhausting	☐ Severe	☐ A lot	☐ Dinnertime	☐ All Day	☐ Falls Asleep
☐ Balance	☐ Cramping	☐ Sickening	☐ Distressing	☐ Always	☐ Evening	☐ All Night	**New Problems with**
☐ Coordination	☐ Gnawing	☐ Fearful	☐ Horrible	☐ Activity	☐ Nighttime	☐ Varies	☐ Bowel Control
☐ Joint-s	☐ Burning	☐ Punishing	☐ Excruciating	☐ With Rest	☐ Varies	☐ Always	☐ Bladder Control

WHERE IS YOUR PAIN NOW ?
Use the Symbols to Mark Where you have Pain on the Body below

Aching	Numbness	Pins/Needles	Burning	Stabbing	Other
△△△	===	OOO	XXX	///	●●●



CIRCLE the Face that Best Describes Your Overall Mood?



IF No Pain as " 0 " and the Worst Pain you ever had is "10"

What is Your Current Pain Level? _______

On A Good Day? ______ **On A Bad Day?** ______ **Overall?** ______

ARE YOU SUICIDAL ? ☐ No ☐ Yes

Your Primary Care Physician is

Do you have Localized Weakness? Mark Only if you have it.

What Side	Rt	Lft	What Side	Rt	Lft	What Side	Rt	Lft
Head/Neck	☐	☐	Arm	☐	☐	Leg	☐	☐
Trunk	☐	☐	Shoulder	☐	☐	Hip	☐	☐
Back	☐	☐	Elbow	☐	☐	Knee	☐	☐
Pelvis	☐	☐	Wrist-Hand	☐	☐	Ankle-Foot	☐	☐

Do you have any In-coordination Problems with the Following?

Head Spine Trunk		Upper Limbs		Lower Limbs	
☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Rt Side	Left Side	Rt Side	Left Side	Rt Side	Left Side
☐	☐	☐	☐	☐	☐

Do you have Any Joint Problems? Mark Only if you have it.

Side?	Rt	Lft	Hand	Side?	Rt	Lft	Side?	Rt	Lft
TMJ	☐	☐	Digit # 1	Thumb	☐	☐	SI	☐	☐
Sternum	☐	☐	Digit # 2	Index	☐	☐	HIP	☐	☐
Shoulder	☐	☐	Digit # 3	Middle	☐	☐	Knee	☐	☐
Elbow	☐	☐	Digit # 4	Ring	☐	☐	Ankle	☐	☐
Wrist	☐	☐	Digit # 5	Little	☐	☐	Foot	☐	☐

In the past 6 months How Many People Wrote Pain Meds for you?

0	1	2	3	4	5	6	7	8	9	10	More
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Have you used any Anti-inflammatory medication?	☐ No	☐ Yes
Have you been in Physical-Occupational Therapy?	☐ No	☐ Yes
History of Physical, Emotional, or Sexual Abuse?	☐ No	☐ Yes
Any History of Mental or Emotional Issues?	☐ No	☐ Yes
Any History of Drug or Alcohol Abuse Problems?	☐ No	☐ Yes
Have you Had Problems Before with Any Doctor?	☐ No	☐ Yes
Have you Ever Failed a Drug Screen or Testing?	☐ No	☐ Yes
Have you Ever been Discharged from an Office?	☐ No	☐ Yes

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From the group below what Descriptions BEST describes you and your current situation?

☐	☐	☐	☐	☐
Asymptomatic Or Intermittent Symptoms	Symptoms with Strenuous Activity Able to do Self-Care Independently	Symptoms with Normal Activity; Able to do Self-Care with Moderate Help but Unassisted	Symptoms with Less than Normal Activity Requires Some Help to do Self Care	Symptoms at Rest Not Able to do Self Care Needs Significant Help to do Self Care

Do you need anyone to help you? ☐ NO ☐ YES WHO ? ________________

What do they do for you? ________________

What AGGRAVATES your Overall Problem-s?

☐ Nothing	☐ Standing	☐ Bathing	☐ Working
☐ Rest	☐ Bending	☐ Shower	☐ Heat
☐ Sitting	☐ Twisting	☐ Dressing	☐ Cold
☐ Laying Down	☐ Reaching	☐ Dishes	☐ Therapy
☐ On Side	☐ Lifting	☐ Housework	☐ Massage
☐ On Back	☐ Climbing	☐ Driving	☐ Meds
☐ On Stomach	☐ Walking	☐ Sports	☐ TENS
☐ Knees Bent	☐ Jogging	☐ Family	☐ E Stim
☐ Legs Up	☐ Running	☐ Friends	☐ Injections
☐ Legs Down	☐ Crawling	☐ Co-workers	☐ Surgery

What HELPS your Overall Problem-s?

☐ Nothing	☐ Standing	☐ Bathing	☐ Working
☐ Rest	☐ Bending	☐ Shower	☐ Heat
☐ Sitting	☐ Twisting	☐ Dressing	☐ Cold
☐ Laying Down	☐ Reaching	☐ Dishes	☐ Therapy
☐ On Side	☐ Lifting	☐ Housework	☐ Massage
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☐ Legs Down	☐ Crawling	☐ Co-workers	☐ Surgery

Current Allergies and Sensitivities Mark ALL that APPLY

☐ NONE	☐ Shell Fish	☐ Lidocaine	☐ Phenol	☐ Steroids
☐ Seasonal	☐ Betadine	☐ Marcaine	☐ Glycerin	☐ Latex
☐ Animals	☐ Iodine	☐ Procaine	☐ Cod Liver	☐ Paper Tape
☐ Foods	☐ IVP Dye	☐ Sarapin	☐ Vitamin A	☐ Cloth Tape

Allergies	***What Happens***

☐ Antibiotics:

☐ Other Allergies:

Any Personal History of the following ? Mark ALL that applies and fill in the blanks as needed.

☐ Tobacco Use	☐ Alcohol Abuse	☐ Drug Abuse	☐ Physical Abuse	☐ Sexual Abuse	☐ Violence	☐ Suicide Attempts
☐ Acid / LSD	☐ Club Drugs	☐ Cocaine	☐ Heroin	☐ Inhalants	☐ Marijuana	☐ Ecstasy/MDMA
☐ Meth	☐ PCP	☐ Rx Abuse	☐ Steroids	☐ Caffeine	☐ Soft Drinks	☐ Diet Soft Drinks
☐ Cigarettes	☐ Cigars	☐ Snuff	☐ Chew	☐ Beer	☐ Wine	☐ Liquor
____ Day	____ Day	____ Day	____ Day	____ Day	____ Day	____ Day
____ Month	____ Month	____ Month	____ Month	____ Month	____ Month	____ Month

I used ☐ Tobacco products for ______ Years ***I used*** ☐ Alcohol for ______ Years ***I used*** ☐ Drugs for ______ Years

I stopped Tobacco products in ________ ***I stopped*** Alcohol in ________ ***I stopped*** Drugs in ________

Have You ever been Arrested for Drugs or Alcohol Problems? ☐ No ☐ Yes ***Have You ever Served Jail Time?*** ☐ No ☐ Yes

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Name ______ **SSN** **XXX-XX-** ______ **DOB** ______ **Date** ______

WHAT PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS ARE YOU TAKING?
PLEASE INCLUDE TOPICAL CREAMS, PACTHES, OINTMENTS, HERBS, VITAMINS & SUPPLIMENTS

Medication ______
It is used for? ______
Side Effects? ______

DOSE	# pills/patch	HOW OFTEN	**DAY TOTAL**
______	______	______ per hrs	______

Helps ☐ Yes ☐ No **Need** ☐ Same ☐ More ☐ Less

Medication ______
It is used for? ______
Side Effects? ______

DOSE	# pills/patch	HOW OFTEN	**DAY TOTAL**
______	______	______ per hrs	______

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