

B. How often does your Numbness occur?

- continuous
- several times a day
- once per day
- once per week
- less than once per week
- never

C. What is the duration of your Numbness?

(Length it lasts)

- none
- seconds
- minutes
- hours
- days
- weeks
- continuous

D. Circle a number below to indicate your **highest** Numbness intensity over the past week

0	1	2	3	4	5	6	7	8	9	10
No Numbness		Mild Numbness		Moderate Numbness		Severe Numbness		Most intense Numbness imaginable		

E. Circle a number below to indicate your **lowest** Numbness intensity over the past week

0	1	2	3	4	5	6	7	8	9	10
No Numbness		Mild Numbness		Moderate Numbness		Severe Numbness		Most intense Numbness imaginable		

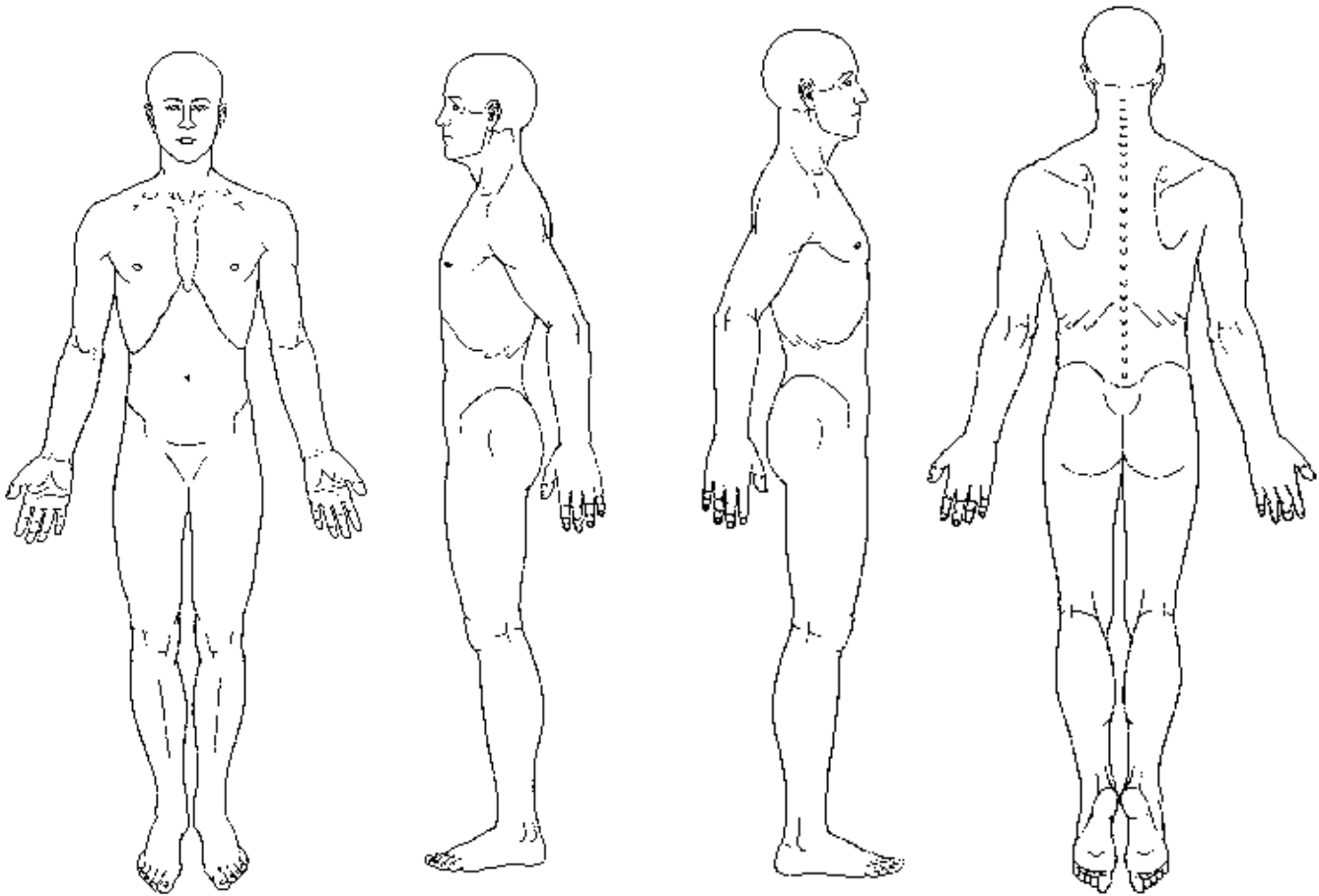
F. Circle a number below to indicate your **usual** Numbness intensity over the past week

0	1	2	3	4	5	6	7	8	9	10
No Numbness		Mild Numbness		Moderate Numbness		Severe Numbness		Most intense Numbness imaginable		

G. Below is a list of words that may describe your pain. Please rate each word on the 0 to 3 point scale to describe your pain. (If you have any).

	None	Mild	Moderate	Severe
Throbbing	0) _____	1) _____	2) _____	3) _____
Shooting	0) _____	1) _____	2) _____	3) _____
Stabbing	0) _____	1) _____	2) _____	3) _____
Sharp	0) _____	1) _____	2) _____	3) _____
Cramping	0) _____	1) _____	2) _____	3) _____
Gnawing	0) _____	1) _____	2) _____	3) _____
Hot-Burning	0) _____	1) _____	2) _____	3) _____
Aching	0) _____	1) _____	2) _____	3) _____
Heavy	0) _____	1) _____	2) _____	3) _____
Tender	0) _____	1) _____	2) _____	3) _____
Splitting	0) _____	1) _____	2) _____	3) _____
Tiring-Exhausting	0) _____	1) _____	2) _____	3) _____
Sickening	0) _____	1) _____	2) _____	3) _____
Fearful	0) _____	1) _____	2) _____	3) _____
Punishing-Cruel	0) _____	1) _____	2) _____	3) _____

H. Please indicate where you have Numbness:



FRONT

LEFT SIDE

RIGHT SIDE

BACK

I. What makes the Numbness **WORSE**? Be Specific.

J. What makes the Numbness **BETTER**? Be Specific.

IV Effects of Numbness

1. Circle the number to indicate how much your Numbness has interfered with your activities this **past week**.

0	1	2	3	4	5	6	7	8	9	10
No Interference	Mild		Moderate			Severe		Complete Interference		

2. Circle the number to indicate how distressed or bothered you have been in the **past week** about the Numbness.

0	1	2	3	4	5	6	7	8	9	10
None	Mild		Moderate			Severe		The most Severe Imaginable		

VIII X-rays and Tests

Please list, in chronological order, all tests and x-rays performed to evaluate your Numbness:

Date	Test	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

XI Previous Treatments

Indicate which of the following treatments you have tried for your Numbness problem:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> antidepressants | <input type="checkbox"/> acupuncture | <input type="checkbox"/> psychotherapy | <input type="checkbox"/> homeopathy |
| <input type="checkbox"/> narcotics | <input type="checkbox"/> chiropractor | <input type="checkbox"/> biofeedback | <input type="checkbox"/> TENS |
| <input type="checkbox"/> nerve blocks | <input type="checkbox"/> massage | <input type="checkbox"/> relaxation training | <input type="checkbox"/> exercise program |
| <input type="checkbox"/> traction | <input type="checkbox"/> physical therapy | <input type="checkbox"/> hypnosis | <input type="checkbox"/> other (list) _____ |

X Previous Medications

List all previous medications you have taken for Numbness:

<u>Name of medicine</u>	<u>Dose</u>	<u>Dates of use</u>	<u>Helpful?</u>	<u>Reason for stopping</u>
_____	_____	_____	YES NO	_____
_____	_____	_____	YES NO	_____
_____	_____	_____	YES NO	_____
_____	_____	_____	YES NO	_____

XI Surgeries

List any operations, hospitalizations, or injuries you have ever had.

<u>Year</u>	<u>Type of Surgery</u>	<u>Hospital</u>	<u>Doctor</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

XII Allergies

List all allergies to medications and the reaction you had to any medicine:

<u>Medicine</u>	<u>Reaction</u>	<u>Medicine</u>	<u>Reaction</u>
_____	_____	_____	_____
_____	_____	_____	_____

XIII Review of Systems

Please check if you have or had any of the following:

A. General

Gastrointestinal

- abdominal pain
- nausea or vomiting
- constipation or diarrhea
- history of ulcers or heartburn

G. Genitourinary

- pregnant
- frequent or hesitant urination
- pain with urination
- blood in urine
- incontinence
- sexual dysfunction

H. Musculoskeletal

- arthritis Type: _____
- osteoporosis
- muscle pain
- muscle wasting
- fractures

I. Neurologic

- numbness
- weakness
- falling or loss of balance
- stroke
- seizures
- memory loss

J. Infections

- Measles
- Mumps
- Chicken Pox
- Rheumatic Fever
- Hepatitis

HIV / AIDS

F.

- weight loss
- poor appetite
- severe fatigue/low energy

B. Skin

- rash
- nail changes
- bumps/nodules
- herpes

C. Head and Neck

- headaches
- visual changes
- mouth problems
- thyroid problems
- neck pain
- difficulty swallowing

D. Hematological

- anemia
- easy bruising
- bleeding disorder
- taking blood thinners

E. Cardiopulmonary

- shortness of breath
- cough
- exercise limitations
- chest pain
- irregular heartbeat
- heart murmurs
- high or low blood pressure
- circulation problems
- ankle swelling

XIV Past Medical Problems: Please indicate any other medical problems you have had.

XV Habits

- A. Smoking: Yes___ No___ Quit ___ Number of Packs/Day____
Number of years smoked _____
- B. Alcohol Use: None ___ Occasional___ Daily ___ How much per week? _____
- C. Recreational Drugs: Current use ? Yes _____; No _____
 ◇ cocaine ◇ amphetamines ◇ marijuana ◇ heroin ◇ other _____
- D. Coffee/Tea/Caffeine: Number of Cups/Day _____
- E. Clenching teeth: Yes___ No___ Grinding Teeth: Yes___ No___
- F. Do you wear an intra oral splint? Yes _____; No _____
- G. Is anyone concerned about your use of alcohol, drugs, or medications? Yes___ No___

XVI Family History

<u>Member</u>	<u>Deceased or Living</u>	<u>Age</u>	<u>Medical Problems</u>
1. Father	_____	_____	_____
2. Mother	_____	_____	_____
3. Siblings	_____	_____	_____
	_____	_____	_____
4. Spouse	_____	_____	_____

Are you adopted? Yes _____; No _____

XVII Social History

- A. Relationship Status
- | | |
|--|------------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Significant Other | <input type="checkbox"/> Divorced |
| ___ Male ___ Female | |
| <input type="checkbox"/> Married | <input type="checkbox"/> Widowed |
- B. Highest level of education you have completed:
- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Less than high school | <input type="checkbox"/> College |
| <input type="checkbox"/> High school | <input type="checkbox"/> Graduate |
| <input type="checkbox"/> Vocational | <input type="checkbox"/> Other _____ |
- C. With whom do you live? Name: _____ Relationship: _____
- D. What is your current employment status?
- | | | |
|---|---|--|
| <input type="checkbox"/> Employed full time | <input type="checkbox"/> Retired | Are you on disability? Yes___ No___
Date disability started: _____
Reason for disability: _____
_____ |
| <input type="checkbox"/> Employed part time | <input type="checkbox"/> Unemployed due to Numbness | |
| <input type="checkbox"/> Self Employed | <input type="checkbox"/> Unemployed due to other reasons: _____ | |
| <input type="checkbox"/> Homemaker | | |
- How long have you been unemployed or retired? _____
- E. Number of hours worked per week: _____ Are you happy with your job? _____
Your current or most recent occupation _____

XVIII *Financial Information*

A. What are your present sources of financial support?

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Personal earnings | <input type="checkbox"/> Spouse's earnings | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Pension/retirement | <input type="checkbox"/> None |
| <input type="checkbox"/> Workman's comp | <input type="checkbox"/> Insurance | |

B. Are you hoping to receive other income or compensation? If so, please indicate:

- | | |
|---|---|
| <input type="checkbox"/> Disability payment | <input type="checkbox"/> Workmen's compensation |
| <input type="checkbox"/> Legal settlement | <input type="checkbox"/> Other (describe) _____ |

C. Do you have any legal action pending related to this Numbness or any other health problem? Yes ___
No ___

If yes please list: Attorneys name _____
Address _____
Phone # _____

XIX *Psychological History*

1. Describe your mood.

2. Do you have problems with any of the following:

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> concentration | <input type="checkbox"/> anxiety | <input type="checkbox"/> homicidal thoughts |
| <input type="checkbox"/> motivation | <input type="checkbox"/> depression | <input type="checkbox"/> appetite |
| <input type="checkbox"/> sleep | <input type="checkbox"/> self-worth | <input type="checkbox"/> suicidal thoughts |

3. Are you currently in therapy Yes ___ No ___

4. If Yes, Name _____: Degree M.D. ___; Ph.D. ___; MFCC ___
Phone # (_____) _____

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