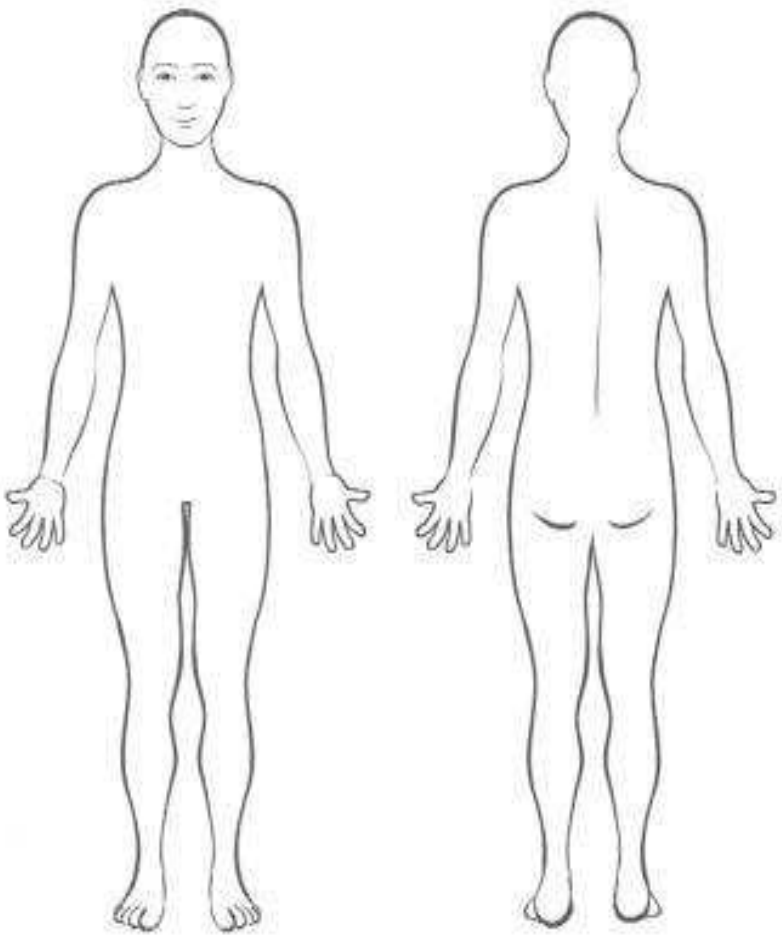
PAIN INFORMATION SHEET

PLEASE MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE SENSATIONS DESCRIBED BELOW.
PLEASE USE THE APPROPRIATE SYMBOL & INCLUDE ALL AREAS.

	****		**====			**OOOO**			**XXXX**		**////
ACHE	****	**NUMBNESS**	**====		**PINS & NEEDLES**	**OOOO**		**BURNING**	**XXXX**	**STABBING**	**////
	****		**====			**OOOO**			**XXXX**		**////



R **L** **L** **R**

WHEN DID THE PAIN START? _____

NAME _____

DATE _____

ELECTRODIAGNOSTIC HEALTH HISTORY FORM

Today's Date: _____

Name: _____ Age: _____ Dominant Hand: ☐ Right ☐ Left

L&I Claim? ☐ Yes ☐ No If yes, date of injury/claim # _____
Personal or Automobile Injury? ☐ Yes ☐ No If yes, date of injury/claim # _____

Primary complaint: _____

Circle all the words that describe your condition:

Numbness	Tingling	Weakness	Worse with standing & walking
Burning	Shooting	Throbbing	Waking up at night

Prior EMG/Nerve Test of the body region we are testing? ☐ Yes ☐ No
If yes, please indicate dates and location: _____

Prior X-ray, CT, or MRI of the body region we are testing? ☐ Yes ☐ No
If yes, please indicate date and location: _____

Medical History:

Diabetes	☐ Yes ☐ No	Bleeding disorder	☐ Yes ☐ No
Thyroid problems	☐ Yes ☐ No	Neuropathy	☐ Yes ☐ No
Pacemaker/Defibrillator	☐ Yes ☐ No	HIV or AIDS	☐ Yes ☐ No
Kidney disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
History of chemo/radiation	☐ Yes ☐ No	Cancer (list below)	☐ Yes ☐ No

Please list all other medical problems: _____

Surgical History:

Cervical spine (neck) surgery	☐ Yes ☐ No	Prior carpal tunnel surgery	☐ Yes ☐ No
Lumbar spine (back) surgery	☐ Yes ☐ No	Prior ulnar nerve surgery	☐ Yes ☐ No
Hip/knee/foot surgery	☐ Yes ☐ No	Shoulder/elbow/wrist surgery	☐ Yes ☐ No

IF YES, please specify details (dates/surgeon/location):

_____

_____

Current Medications: _____

_____

Do you have **allergies** to latex products? ☐ Yes ☐ No If yes, type or reaction _____
Do you have **allergies** to medications? ☐ Yes ☐ No If list, please list: _____

Are you on any **blood thinners?** ☐ Yes ☐ No **(**Ex: Warfarin/Coumadin, Plavix, Xarelto, Pradaxa)

Family History of a Peripheral Neuropathy or Muscle Disorder**?** ☐ Yes ☐ No

Social History:

Do you smoke?	☐ Yes ☐ No	If yes, how much? _____
Do you drink alcohol?	☐ Yes ☐ No	If yes, how much? _____

Gen: fever, chills, weight loss	☐ Yes ☐ No	**If yes,** describe: _____
Neuro: sensory loss, fainting, seizures, headaches	☐ Yes ☐ No	**If yes,** describe: _____
Endo: temp intolerance, excessive thirst, excessive urination	☐ Yes ☐ No	**If yes,** describe: _____