HISTORY OF PRESENT ILLNESS FORM (DR. RICE)

Hand Dominance: Right Left

Work-related Injury: Yes No

Date of Onset: _____

How long has the pain been present?: Days Months Years

Character of Pain/problem: Burning Tingling Numbness Weakness Snapping

Sharp stabbing Dull Achy Throbbing Clicking Catching Popping

Neck pain with radiation up neck or down arm to hand: Yes No

Back pain with radiation up spine or down the leg: Yes No

Intensity of Pain (0-10, 0 being no pain, 10 being worst pain of your life): _____

Is the pain *increasing*, *decreasing*, or *staying the same* since its onset? CIRCLE ONE

Activities you are unable to perform due to the pain/dysfunction: CIRCLE WHICH APPLY

Sport Throwing Sleeping on that side Lifting Reaching Overhead

Other activities: _____

Previous Treatment:

Activity modification (such as rest, ice, elevation, or immobilization): YES NO

Medications (CIRCLE ANY THAT APPLY): None Tylenol Naproxen/Aleve

Ibuprofen/Advil/Motrin Prescription NSAID (ex. Mobic, Voltaren, Celebrex)

Muscle relaxer (ex. Flexeril) Opioid (ex. Vicodin, Percocet, Norco, Oxydodone, Methadone)

Bracing/Immobilization (such as sling or brace): Yes No

Physical Therapy: Yes No

Injections (steroid, cortisone, gel, visco): Yes No

Surgical procedures to area of concern: Yes No If yes, what?: _____

Response to <u>previous</u> treatment as percentage of original pain (please circle):

0% 10% 50% 90% 100% Other: _____

Imaging/Testing Completed to Date: X-ray MRI CT EMG Other:_____

Goal of Treatment (CIRCLE ANY THAT APPLY): Resolve Pain Restore Function Return to work

Return to Sport Other: _____