Mark N. Hashim, M.D.

Patient Evaluation Form

Please complete this form and **return completed form** to the office via fax, mail, email or hand delivery.

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PLEASE PRINT CLEARLY. Fill out this form as completely as possible.

DATE: _____ Email address_____

NAME: _____ AGE: _____

HEIGHT: _____ WEIGHT: _____ Mobile Phone Number_____

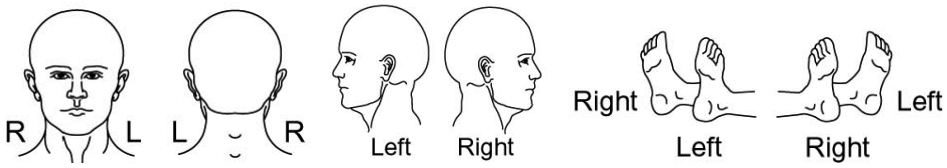
PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

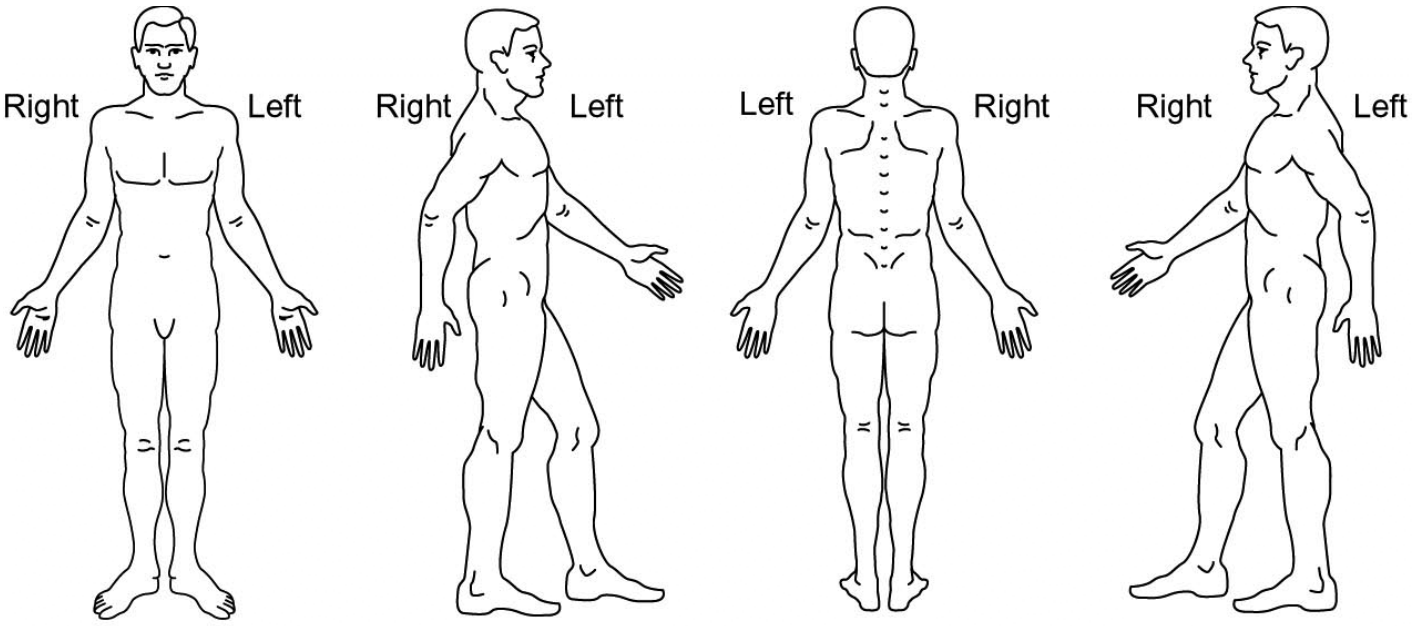
PLEASE LIST ALL PHYSICIANS (or mental health professionals) that you have consulted:

NAME	DATE LAST SEEN	OFFICE PHONE NUMBER

Use the following diagrams to label where the pain is located. This will be what problem area to be discussed with the physician. Please label the area with the following letters.

B = BURNING
S = SHARP
D = DULL ACHE
N = NUMBNESS / TINGLING





HOW did your pain start?

☐ auto accident ☐ fall (not at work) ☐ after surgery

☐ work related ☐ just started ☐ other; describe below:

_____

_____

_____

WHEN did your pain start? _____

CHECK the number that indicates the degree of pain you are in **NOW** (0=no pain):

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

CHECK the number that indicates the AVERAGE pain you felt in the PAST WEEK:

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

In the last 2-3 weeks, WHEN does your pain occur:

☐ constant ☐ intermittent (on & off) ☐ less then 8 hours/day ☐ 8-16 hours/day

What **INCREASES** your pain:

☐ sitting ☐ walking ☐ standing ☐ work ☐ other; describe below:

_____

What **DECREASES** your pain:

☐ rest ☐ physical therapy ☐ lying down ☐ relaxation ☐ injections

☐ drugs ☐ heat ☐ cold ☐ not working

☐ treatment in emergency room ☐ other; describe below:

_____

CHECK any of the following treatments that you have tried for your pain:

Pain Clinic / Anesthesiologist	☐ Better	☐ Same	☐ Worse
Anti-depressant medications	☐ Better	☐ Same	☐ Worse
Trigger point injections	☐ Better	☐ Same	☐ Worse
Epidural steroid injections	☐ Better	☐ Same	☐ Worse
Biofeedback or relaxation	☐ Better	☐ Same	☐ Worse
TNS unit (transcutaneous nerve stim)	☐ Better	☐ Same	☐ Worse
Physical therapy	☐ Better	☐ Same	☐ Worse
Home exercises	☐ Better	☐ Same	☐ Worse
Hypnosis / psychotherapy	☐ Better	☐ Same	☐ Worse
Acupuncture	☐ Better	☐ Same	☐ Worse
Chiropractic	☐ Better	☐ Same	☐ Worse
Massage therapy	☐ Better	☐ Same	☐ Worse
Pain killers	☐ Better	☐ Same	☐ Worse

Does your pain keep you from falling asleep at night? ☐ Yes ☐ No

Does your pain wake you up at night? ☐ Yes ☐ No

What are your past or current MEDICAL problems:

☐ stroke ☐ angina ☐ hepatitis ☐ epilepsy ☐ heart disease ☐ arthritis

☐ cancer ☐ asthma ☐ diabetes ☐ migraines ☐ easy bleeding ☐ HIV

☐ lung disease ☐ recent weight loss ☐ other; describe below:

_____

List any surgeries:

SURGERY:	DATE:

Do you take aspirin? ☐ Yes ☐ No If yes, last dose & date: _____

Do you use any anticoagulants (like heparin, aspirin or coumadin): ☐ Yes ☐ No

Do you use recreational drugs or medications prescribed to someone else?
☐ Yes ☐ No If YES, describe below:

_____

_____

_____

List **ALL** medications, nutritional supplements and over the counter medications:

NAME:	STRENGTH:	HOW OFTEN:

List the medications you are ALLERGIC to or have had problems with:

MEDICATION: REACTION:

Please check any items that apply to **YOU** currently or in the past:

☐ heart trouble	☐ heart or chest pain	☐ bleeding problems
☐ breathing problems	☐ frequent nausea/vomiting	☐ loss of bowel control
☐ frequent diarrhea	☐ frequent constipation	☐ pain on urination
☐ diabetes	☐ joint stiffness/swelling	☐ frequent infections
☐ seizures	☐ severe headaches	☐ strokes or TIA's
☐ high blood pressure	☐ shortness of breath at rest	☐ swollen ankles
☐ frequent pneumonia	☐ stomach ulcers	☐ frequent laxatives
☐ loss of urinary control	☐ urinary tract infections	☐ joint pain
☐ thyroid problems	☐ use of stool softeners	☐ skin problems
☐ numbness arms or legs	☐ weakness of arms or legs	☐ fainting spells

☐ OTHER:

Have any of your relatives had: ☐ cancer ☐ heart disease ☐ neurologic disease ☐ muscular disease

Have you gained or lost more than 10 pounds in the last year?	☐ Yes	☐ No
FOR **WOMEN** ONLY:		
Are you pregnant?	☐ Yes	☐ No
Are you trying to get pregnant?	☐ Yes	☐ No
FOR **MEN** ONLY:		
Do you have problems with erections?	☐ Yes	☐ No
Do you smoke? How much?	☐ Yes	☐ No
Do you drink alcohol? How much?	☐ Yes	☐ No
Has anyone ever complained about your drinking?	☐ Yes	☐ No
If yes, who?		
Do you drink caffeine? How much?	☐ Yes	☐ No
Are you married?	☐ Yes	☐ No

Current Employer:

Occupation:

Job description: _____

How long with this employer? _____

Are you currently working? ☐ Yes ☐ No Date last worked: _____

If not working, who took you off work? _____

When will your off work slip expire? _____

Are you on Worker's Comp? ☐ Yes ☐ No

Date started: _____

Are you on disability? ☐ Yes ☐ No

Date started: _____

Type: ☐ social security disability ☐ long term disability ☐ short term disability

☐ other: _____

What do you get disability for: _____

Are you in a lawsuit with Workers Comp? ☐ Yes ☐ No

Are you involved in a lawsuit regarding an auto accident? ☐ Yes ☐ No

Are you involved in a lawsuit regarding a disability claim? ☐ Yes ☐ No

If you are involved in a lawsuit, who is the lawsuit against? _____

How has pain affected your personality? (check all that apply)

☐ no effect	☐ alert	☐ cheerful	☐ get along well
☐ slightly upset	☐ irritable	☐ disagreeable	☐ complaining
☐ moderately upset	☐ unhappy	☐ anxious	☐ uncooperative
☐ severely upset	☐ quite depressed	☐ bitter	☐ withdrawn
☐ totally incapacitated	☐ panicked	☐ severe withdrawal	☐ avoid everyone
☐ moody	☐ dull	☐ desperate	

Since the pain, what are you concerned about? (check all that apply **now**)

☐ loss of recreational activities	☐ ability to earn income
☐ memory/concentration difficulties	☐ poor sleep and daytime fatigue
☐ sexual desire, interest or ability	☐ unidentified medical problems
☐ the pain lasting forever	☐ other; describe below:

_____

Have you ever seen a counselor, psychologist or psychiatrist? ☐ Yes ☐ No

(if yes, please include on list page 1)

What treatments have you had for emotional problems? (check all that apply)

☐ ECT ☐ counseling ☐ medication ☐ group therapy ☐ other:

_____

Do you want to see a pain psychologist to help you deal with the pain?

☐ Yes ☐ No

What diagnostic studies have been done in the **last 5 years**? Please give area of body studied and date of study. Please have the REPORTS of these studies available for your first visit.

MRI DATE:	**PART OF BODY:**	**DO YOU HAVE REPORT?**	**NAME OF FACILITY:**
_____	_____	☐ No ☐ Yes	_____
_____	_____	☐ No ☐ Yes	_____
MYELOGRAM DATE:			
_____	_____	☐ No ☐ Yes	_____

CT SCAN DATE:

_____	_____	☐ No	☐ Yes	_____
_____	_____	☐ No	☐ Yes	_____

XRAY DATE:

_____	_____	☐ No	☐ Yes	_____
_____	_____	☐ No	☐ Yes	_____

EMG DATE:

_____	_____	☐ No	☐ Yes	_____

BONE SCAN DATE:

_____	_____	☐ No	☐ Yes	_____

This questionnaire consists of 21 groups of statements. Please read each group of Statements carefully, and then pick out the **ONE STATEMENT** in each group that best describes the way you have been feeling during the past **TWO** weeks, including today. Check the box beside the statement you have picked. If several statements in a group seem to apply equally well, check the highest number for that group. Be sure you do not choose more than one statement for any group, including #16 or #18.

1. ☐ 0 I do not feel sad.
   ☐ 1 I feel sad much of the time.
   ☐ 2 I am sad all the time.
   ☐ 3 I am so sad or unhappy that I can't stand it.

2. ☐ 0 I am not discouraged about my future.
   ☐ 1 I feel more discouraged about my future than I used to be.
   ☐ 2 I do not expect things to work out for me.
   ☐ 3 I feel my future is hopeless and will only get worse.

3. ☐ 0 I do not feel like a failure.
   ☐ 1 I have failed more than I should have.
   ☐ 2 As I look back, I see a lot of failures.
   ☐ 3 I feel I am a total failure as a person.

4. ☐ 0 I get as much pleasure as I ever did from the things I enjoy.
   ☐ 1 I don't enjoy things as much as I used to.
   ☐ 2 I get very little pleasure from the things I used to enjoy.
   ☐ 3 I can't get any pleasure from the things I used to enjoy.

5. ☐ 0 I don't feel particularly guilty.
   ☐ 1 I feel guilty over many things I have done or should have done.
   ☐ 2 I feel quite guilty most of the time.
   ☐ 3 I feel guilty all the time.

6. ☐ 0 I don't feel I am being punished.
   ☐ 1 I feel I may be punished.
   ☐ 2 I expect to be punished.
   ☐ 3 I feel I am being punished.

7. ☐ 0 I feel the same about myself as ever.
☐ 1 I have lost confidence in myself.
☐ 2 I am disappointed with myself.
☐ 3 I dislike myself.

8. ☐ 0 I don't criticize or blame myself more than usual.
☐ 1 I am more critical of myself then I used to be.
☐ 2 I criticize myself for all my faults.
☐ 3 I blame myself for everything bad that happens.

9. ☐ 0 I don't have any thoughts of killing myself.
☐ 1 I have thoughts of killing myself, but I would not carry them out.
☐ 2 I would like to kill myself.
☐ 3 I would kill myself if I had the chance.

10. ☐ 0 I don't cry anymore than I used to.
☐ 1 I cry more than I used to.
☐ 2 I cry over every little thing.
☐ 3 I feel like crying, but I can't.

11. ☐ 0 I am no more restless or wound up than usual.
☐ 1 I feel more restless or wound up than usual.
☐ 2 I am so restless or agitated that it's hard to stay still.
☐ 3 I am so restless or agitated that I have to keep moving or doing something.

12. ☐ 0 I have not lost interest in other people or activities.
☐ 1 I am less interested in other people or things than before.
☐ 2 I have lost most of my interest in other people or things.
☐ 3 It's hard to get interested in anything.

13. ☐ 0 I make decisions about as well as ever.
☐ 1 I find it more difficult to make decisions than usual.
☐ 2 I have much greater difficulty in making decisions than I used to.
☐ 3 I have trouble making any decisions.

14. ☐ 0 I don't feel I am worthless.
☐ 1 I don't consider myself as worthwhile and useful as I used to.
☐ 2 I feel more worthless as compared to other people.
☐ 3 I feel utterly worthless.

15. ☐ 0 I have as much energy as ever.
☐ 1 I have less energy than I used to have.
☐ 2 I don't have enough energy to do very much.
☐ 3 I don't have enough energy to do anything.

16. ☐ 0 I have not experienced any change in my sleeping pattern.
☐ 1a I sleep somewhat more than usual.
☐ 1b I sleep somewhat less than usual.
☐ 2a I sleep a lot more than usual
☐ 2b I sleep a lot less than usual.
☐ 3a I sleep most of the day.
☐ 3b I wake up 1-2 hours early and can't get back to sleep.

17. ☐ 0 I am no more irritable than usual.
☐ 1 I am more irritable than usual.
☐ 2 I am much more irritable than usual.
☐ 3 I am irritable all the time.

18. ☐ 0 I have not experienced any changes in my appetite.
☐ 1a My appetite is somewhat less than usual.
☐ 1b My appetite is somewhat greater than usual.
☐ 2a My appetite is much less than before.
☐ 2b My appetite is much greater than usual.
☐ 3a I have no appetite at all.
☐ 3b I crave food all the time.

19. ☐ 0 I can concentrate as well as ever.
☐ 1 I can't concentrate as well as usual.
☐ 2 It's hard to keep my mind on anything for very long.
☐ 3 I find I can't concentrate on anything.

20. ☐ 0 I am no more tired or fatigued than usual.
☐ 1 I get more tired or fatigued more easily than usual.
☐ 2 I am too tired or fatigued to do a lot of the things I used to do.
☐ 3 I am too tired or fatigued to do most of the things I used to do.

21. ☐ 0 I have not noticed any recent change in my interest in sex.
☐ 1 I am interested in sex than I used to be.
☐ 2 I am much less interested in sex now.
☐ 3 I have lost interest in sex completely.

BDI-II

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