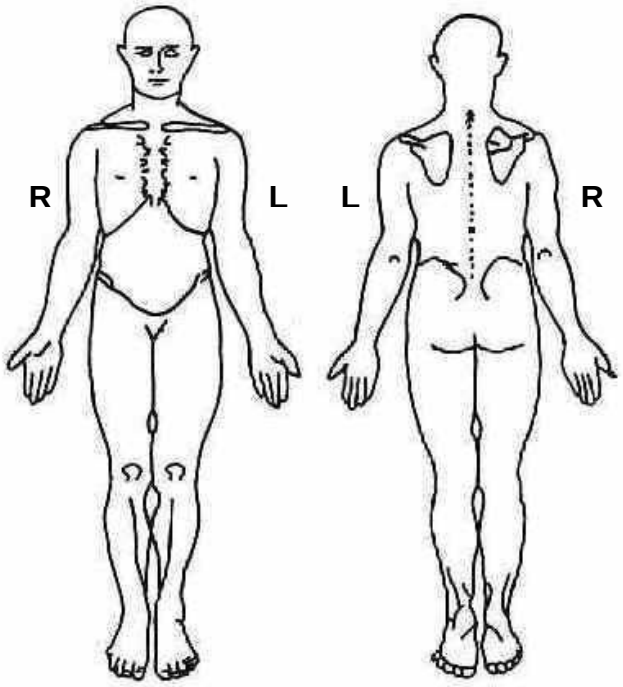
1. Your problem/pain is:

	Better	Worse	No Different
When coughing or sneezing…….	☐	☐	☐
When you wake up in the morning…...	☐	☐	☐
Mid-day……	☐	☐	☐
Evening……....	☐	☐	☐
In the middle of the night…….	☐	☐	☐
Lying on your:			
○ Side……..	☐	☐	☐
○ Back…….	☐	☐	☐
○ Stomach……	☐	☐	☐
When you urinate or move your bowels	☐	☐	☐
Sitting……	☐	☐	☐
Rising from sitting……	☐	☐	☐
Standing……	☐	☐	☐
Walking……	☐	☐	☐
Leaning forward……	☐	☐	☐
Bending forward……	☐	☐	☐
Extending backwards……	☐	☐	☐
Looking up……	☐	☐	☐
Looking down……	☐	☐	☐
Turning head……....	☐	☐	☐
Change of position……	☐	☐	☐
Driving……..	☐	☐	☐
Sexual activity……..	☐	☐	☐
Other (explain)_____	☐	☐	☐



FRONT ANTERIOR **BACK POSTERIOR**

2. Does your pain cause:

☐ Depression ☐ ☐
☐ Emotional stress ☐
☐

3. Does your pain impact:

☐ Employment ☐ ☐
☐ Social activity ☐
☐ Daily activity ☐ ☐

4. Currently working? ☐Yes ☐No

If yes: ☐ Full Time ☐ Part Time ☐ Hourly

If no: Date last worked _____

On disability? ☐ Yes ☐ No

Reason for not working:

_____
_____
_____

5. Is the pain related to a:

☐ Motor vehicle accident
Date of accident: _____
☐ Work related injury
Date of injury: _____
☐ None of the above

6. Where is your pain? How does it feel? Draw your pain using the following key. Do not indicate areas of pain which are not related to your present injury or condition.

KEY

Stabbing	/ / / / /
Burning	X X X
Pins and needles	O O O
Aching/Throbbing	^ ^ ^ ^
Numbness	= = = =
Other	. . . . .

7. How severe is your pain at worst? Circle which number applies.
(0=no pain, 10=worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

8. How severe is your pain at best? Circle which number applies.
(0=no pain, 10=worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

THE POLYCLINIC

Consultation

Physical Medicine

Dr. Xiangping Pearl Ren
(206) 860-5470

Name _____ Account # _____ DOB ___/___/____

Marital/Partner Status _____Type of Work _____ Ht: __'__" Wt: _____

Referring Doctor:_____ His/Her Phone # (____) _____ - _____

When did this pain start? _____

Current symptoms: _____

Treatments to date for current symptoms:

- ☐ Pain Medication (please list) _____
- ☐ Physical Therapy
- ☐ Massage
- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Epidural/Spinal Injection

Medical conditions/chronic illness: _____

Previous surgeries (name, date, location): _____

Are you allergic to any medications? Reaction? _____

Personal History:

- Do you smoke ☐ Never ☐ Current If yes, how often _____ ☐ Former If yes, year quit _____

- Do you drink alcohol ☐ Never ☐ Current If yes, how often _____ ☐ Former If yes, year quit _____

- Major Medical Conditions of Family:
  Mother _____ Sibling(s) _____
  Father _____ Children _____

(*Please turn over and complete back side of page. Thank you*)

Medication List

Non-Polyclinic primary care only this page

(Please include vitamins, supplements, and over the counter)

Name of Medication	Dosage	Number of pills	Times per day