**Midwest Pain Management Associates, LTD**
**John V. O'Hara, MD, DAAPM**

640 East St. Charles Rd. Ste 212
Carol Stream, IL 60188

*(Please Print Clearly)*

Patient Name: _____ Male ❒ Female ❒
*First* *Middle Initial* *Last*
Home Address: _____ City:_____ State:_____ Zip: _____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

Date Of Birth: _____ Age: _____

**PLEASE MARK YOUR MAJOR COMPLAINTS THAT YOU HAVE EXPERIENCED:**

| | PAST | PRESENT |
|---|---|---|
| Low back pain | ❒ | ❒ |
| Mid back pain | ❒ | ❒ |
| Neck pain | ❒ | ❒ |
| Shoulder pain | ❒ | ❒ |
| Headaches | ❒ | ❒ |
| Hip pain | ❒ | ❒ |

| | PAST | PRESENT |
|---|---|---|
| Arthritis | ❒ | ❒ |
| Knee pain | ❒ | ❒ |
| Foot pain | ❒ | ❒ |
| Heel pain | ❒ | ❒ |

Have you **ever** had numbness/tingling? ❒ No ❒ Yes
Where?_____

**Is your pain related to:** ❒ **work?** ❒ **car accident ?** **If so, date:**_____

**When did this complaint begin?** _____

**Is your complaint getting:** ❒ **better** ❒ **same** ❒ **worse**

**Describe how your pain feels: (numbe,achy,burning)** _____

**Is your pain:** ❒ **constant** ❒ **comes and goes**

**What makes it:** **better?** _____ **Worse?** _____

**What have you done for it?** *(Hot packs, ice, stretchng, etc)* _____

**Are you taking medications for this probem?** _____

**What is your occupation?**_____

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***Please Check And Describe:*** ☐ Appendectomy ☐ Tonsilectomy ☐ Gall Bladder ☐ Hernia
☐ Back/Neck Surgery ☐ Broken Bones ☐ Other/Description:_____

_____

Major Accident or Falls: _____

Hospitilization (Other Than Above): _____

**Below are a list of diseases which may seem unrelated to the purpose of you appointment.**

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

| | | | | |
|---|---|---|---|---|
| ☐ Pneumonia | ☐ Mumps | ☐ Pleurisy | ☐ Measles | ☐ Epilepsy/Seizures |
| ☐ Rheumatic Fever | ☐ Polio | ☐ Tuberculosis | ☐ Anemia | ☐ Eczema |
| ☐ Whooping Cough | ☐ Small Pox | ☐ Diabetes | ☐ Cancer | ☐ Mental Disorders |
| ☐ Heart Disease | ☐ Thyroid | ☐ Arthritis | ☐ Epilepsy | ☐ Asthma |
| ☐ High Bld Pressure | ☐ Ulcers/Gerd | ☐ Glaucoma | ☐ Hepatitis | |
| ☐ Bleeding problems | ☐ Kidney Disease | | | |

**Family Health History (***Associated health problems of relatives*): _____

_____

**Deaths in immediate family:**

| Cause of parents or siblings death | Age at death |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**EXERCISE**
☐ None
☐ Moderate
☐ Daily
☐ Heavy
Do You Stretch? ____Yes ____No

**WORK ACTIVITY**
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor
☐ Computer Work
Do You Like Your Job? ☐ Y ☐ N

**SOCIAL HISTORY**
☐ Smoking Pack/Day_____
☐ Alcohol Drinks/Week____
☐ Coffee/Pops Cups/Day____
☐ Sugar Per Day_____
☐ Stress Reason_____
☐ Rec. Drugs_____

Medications: _____

Allergies:_____

Vitamins/Herbs/Minerals:_____

**Assignment of Benefits/Release of Information:**

I authorize payment of insurance benefits directly to the above physician. I am financially responsible for non-covered services. I authorize the physician to release any information required to process my claims. This authorization shall remain in effect until such time as it is revoked by me.

**Patient's signature:** _____ **Date:** _____