PALM TREE
INTERVENTIONAL
PAIN MANAGEMENT
Pain Relief Starts Here

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Auto-PIP Assessment Form

Name: _____ Date:_____/_____/_____ DOB:_____/_____/_____

1. Location of injury-related pain? _____
2. Date of injury? _____
3. How did the accident happen? __Rear ended __T-boned __Head on collision Other please describe_____
4. *How soon after the accident did you develop symptoms?* _____
5. *Did any part of the body strike the inside of the vehicle (e.g, knee strike dashboard, head hit roof or headrest?* YES or NO *If yes, what part?* _____
6. *Was anyone else in the car?* YES or NO *If yes, were they hurt?* _____
7. *Were you the driver?* YES or NO
   a. *If no, where were you sitting?* _____
8. *Were you wearing a seatbelt?* YES or NO *Did the airbag deploy?* YES or NO
9. *Did you lose consciousness?* YES or NO
10. *Were you able to exit from your car after the accident?* YES or NO
11. *Can you estimate how fast the vehicles were traveling?* YES or NO *If yes, how fast?* _____
12. *Were you evaluated at a hospital after the accident?* YES or NO *If yes, how long?* _____
13. Describe your pain (Circle all that apply):

    A spasm, aching, burning, burning, cold, cramping, dull, numb, pressure, sharp, shock-like, shooting, squeezing, stabbing, stinging, tenderness, tingling

14. Does the pain radiate anywhere? YES, NO If yes, where? _____
15. Please rate your pain on a scale of 1-10: Worst Pain? _____ Pain at its best? _____
16. *Do you have leg pain?* YES or NO *Low back pain?* YES or NO *Which is worst?* _____
17. *Do you have neck pain?* YES or *NO* *Arm pain?* YES or NO *Which is worst?* _____
18. *Do you have weakness in any arms or legs?* YES or NO *If yes, where?* _____
19. When during the day do you have your pain? _____
20. What makes your pain better? _____
21. What makes your pain worse? _____
22. Have you received any medical care for your symptoms? YES NO
23. *If yes, what treatment(s)? Physical Therapy Chiropractic Pain Management*
24. *Describe your treatment(s).* _____
25. *Has there been any change in your symptoms? (new pain, less pain, increased pain)?* _____
26. *Have any pains resolved?* _____
27. *Have you been treated by another physician for this injury?* _____
28. *Are you improved/same/worse?* _____
29. *Have you ever had neck or back surgery before? YES, NO If yes, what surgery?* _____
30. Are you taking any medication to help with the pain? YES, NO If yes, what medications? _____
31. What NSAIDS are you taking? (Circle all that apply) Ibuprofen Naproxen Aspirin Meloxicam Diclofenac Tylenol
32. Have you had an MRI and/or X-RAYS? YES or NO If yes, when? _____
33. Have you had a previous work injury or motor vehicle accident? YES or NO
34. What was your functional status prior to the injury? _____
35. What was your functional status after the injury? _____
36. Do you have any constipation? YES, NO SOMETIMES

CURRENT MEDICATION LIST (please add dosages):

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY:

_____

_____

ALLERGIES:

_____

SURGICAL HISTORY:

_____

_____

FAMILY HISTORY:

_____

_____