MICROCURRENT EVALUATION

Name ________________________________ Age ______ Date of Birth _______________ Today's Date _____/_____/_____

A. CURRENT HEALTH PROBLEMS: Why are you coming to see Dr. Sullivan-Durand? Please list the symptoms that you would like to address. Please note: Pain diagram , Pain History and Treatment History on following pages

1. ____

2. ____

3. ____

B. MEDICATIONS/HERBS/SUPPLEMENTS: Please refer to the bottles of all that you are taking and complete the chart below. If you need more space, continue on reverse side of this paper.

Prescription Medications		**Herbs or Vitamin Supplements**		**Over the Counter Medications**	
Name/ Strength (#mg)	# of pills/# of times per day	Name/ Strength (#mg)	# of pills/# of times per day	Name/ Strength (#mg)	# of pills/# of times per day
e.g. Levothyroxine 25 mcg	__2___/___1___	Vital Nutrients B complex	__1___/___2___	Ibuprofen 200 mg ________	__2___/_2-3 ____
____________________	______/_______	____________________	______/_______	____________________	______/______
____________________	______/_______	____________________	______/_______	____________________	______/______
____________________	______/_______	____________________	______/_______	____________________	______/______
____________________	______/_______	____________________	______/_______	____________________	______/______
____________________	______/_______	____________________	______/_______	____________________	______/______
____________________	______/_______	____________________	______/_______	____________________	______/______

C. ACTIVE HEALTH PROBLEMS for which you are taking medication or currently receiving other treatment, even if they are stable and will not be addressed by Dr. Sullivan-Durand

1. ____________________________ Year of Onset__________ 4. ____________________________ Year of Onset__________

2. ____________________________ Year of Onset__________ 5. ____________________________ Year of Onset__________

3. ____________________________ Year of Onset__________ 6. ____________________________ Year of Onset__________

D. PAST MEDICAL PROBLEMS including Significant Childhood Illnesses, Bacterial/Viral infections, Hospitalizations, Surgeries.

Mo/Yr	Illness/Infections/Hospitalizations	Mo/Yr	Surgeries
______	____________________________________	______	____________________________________
______	____________________________________	______	____________________________________
______	____________________________________	______	____________________________________
______	____________________________________	______	____________________________________
______	____________________________________	______	____________________________________

E. ALLERGIES to List	MEDICATIONS	FOOD	ENVIRONMENT
	______________________	________________	____________________________
	______________________	________________	____________________________
	______________________	________________	____________________________

F. Name/Address of Primary Care Provider: ____

Date of Last Office Visit _______________ Is your physician aware of your visit with Dr. Sullivan-Durand? _______________

Name /Address of Other Providers: ____

G. MUSCULOSKELETAL PAIN DIAGRAM : Using the symbols given below, please mark the areas on your body where you feel the described sensations. Include all affected areas and be as detailed as possible. You may use colored pencils if available.

ACHE

SHARP

NUMB 0000 0000

TINGLING

BURNING XXX XXX

PAIN HISTORY

What was the approximate date of onset? ____________________ Did symptoms begin: Suddenly Gradually

Was onset due to an injury? ____YES ___ NO Were you at work or driving a car when you were injured? ____YES ____ NO

Please describe life and health circumstances at the time of onset, including stresses that were present: ______________________

____

____

How many hours per week were you working outside of the home (including commute) at onset?___________________________

How many hours per week were you working inside the home at onset?____

Does the pain significantly interfere with your life? ___YES ____ NO If so, how? ______________________________________

____

TRAUMA/ACCIDENT HISTORY Please complete the following questions for significant accidents/injuries:

MO/YR	NATURE OF ACCIDENT	INJURED AREAS	TREATMENT
________	______________________________	____________________________	______________________
________	______________________________	____________________________	______________________
________	______________________________	____________________________	______________________
________	______________________________	____________________________	______________________

List Treatments (Medications, Massage, Chiropractic, Exercises, etc.) that you have tried for these symptoms.

Type of Treatment	Started When?	Currently Using?	If you are currently using	If discontinued, check reason
		_____ YES _______NO	_____ Helps _____ Doesn't Help _____ Don't Know if it helps	_____ Side Effects _____ Didn't Work _____ Too expensive
		_____ YES _______NO	_____ Helps _____ Doesn't Help _____ Don't Know if it helps	_____ Side Effects _____ Didn't Work _____ Too expensive
		_____ YES _______NO	_____ Helps _____ Doesn't Help _____ Don't Know if it helps	_____ Side Effects _____ Didn't Work _____ Too expensive
		_____ YES _______NO	_____ Helps _____ Doesn't Help _____ Don't Know if it helps	_____ Side Effects _____ Didn't Work _____ Too expensive
		_____ YES _______NO	_____ Helps _____ Doesn't Help _____ Don't Know if it helps	_____ Side Effects _____ Didn't Work _____ Too expensive
		_____ YES _______NO	_____ Helps _____ Doesn't Help _____ Don't Know if it helps	_____ Side Effects _____ Didn't Work _____ Too expensive
		_____ YES _______NO	_____ Helps _____ Doesn't Help _____ Don't Know if it helps	_____ Side Effects _____ Didn't Work _____ Too expensive

FIBROMYALGIA QUESTIONS: Please complete the following questions.

1. Have you had widespread pain for more than 3 months in **all four quadrants** of your body (i.e. above and below the waist and on both sides of the body)? _______YES _______ NO
2. Have you had pain along your spine in your neck, mid-back, or low back or along the front of your chest for more than 3 months at a time? _____YES _____NO
3. Have you ever been diagnosed as having Fibromyalgia? _____YES _____ NO When/By Whom?______________________
4. Please rate the following symptoms on a scale of 0 (not present), 1-2 (mild) up to 10 (severe)

a. Muscle Pain	0	1	2	3	4	5	6	7	8	9	10
b. Joint Pain	0	1	2	3	4	5	6	7	8	9	10
c. Joint Swelling	0	1	2	3	4	5	6	7	8	9	10
d. Numbness/Tingling	0	1	2	3	4	5	6	7	8	9	10
e. Fatigue	0	1	2	3	4	5	6	7	8	9	10
f. Sleep Problems	0	1	2	3	4	5	6	7	8	9	10
g. Impaired Memory	0	1	2	3	4	5	6	7	8	9	10
h. Impaired concentration	0	1	2	3	4	5	6	7	8	9	10
i. Depression	0	1	2	3	4	5	6	7	8	9	10
j. Anxiety/Nervousness	0	1	2	3	4	5	6	7	8	9	10
k. Headaches	0	1	2	3	4	5	6	7	8	9	10
l. Irritable Bowel	0	1	2	3	4	5	6	7	8	9	10

H. WOMEN ONLY:

1. Are you still menstruating? Yes / No (If no, go to Question 2.)

   Are your Periods: Regular / Irregular Date of Last Menstrual Period: ___________________________

   Please describe difficulties with menstruation, if any, including PMS : ______________________________________

   ____

2. If not menstruating, was your menopause: Natural Surgical Chemotherapy-related

   Month/Year of Last Period ________/_________ When did your periods become irregular? ___________________

   Please describe symptoms of menopause, if any:____

   ____

I. ACTIVITY / EXERCISE

1. Do you exercise on a regular basis? ____yes ____no _______would if I was physically able to exercise

Activity (e.g., walking, biking, swimming)	Frequency (daily, weekly, monthly)
___________________________	_____________________________
___________________________	_____________________________
___________________________	_____________________________

2. Do you stretch your muscles before or after your workout? Yes / No Before / After
3. Do you perform any weight training? Yes / No What do you do and how often?__________________________
4. Do you have any questions about exercise? List. ____

J. SLEEP/REST

1. Number of hours of sleep per night? ______ Do you feel rested upon awakening? Yes / No
2. Problems with insomnia? (Check all that apply)

   _____ Trouble falling asleep

   _____ Waking in the ***middle of the night*** and having trouble going back to sleep?

   _____ Waking up ***too early*** and having trouble going back to sleep?
3. Do you nap? Yes / No Duration? __________ Do you feel refreshed? Yes / No
4. Do you use sleeping aids? Yes / No If yes, for how many months/ years? ___________

   If yes, please specify type and frequency: ____

5, Have you ever had a Sleep Study? ________ If so, when and where?____

   What were the results? ____

K. RELAXATION

Do you meditate or practice a relaxation technique? Yes / No How often? _______________

If yes, please check those that apply:

____yoga ____imagery ____abdominal breathing ____meditation ____Tai Chi

____progressive muscle relaxation ____prayer ____other: _______________________________

L. FAMILY HISTORY

	Age	If deceased, Note Age/Cause	Medical and psychological illnesses
Biological mother	___	________________________	____
Step/Adoptive mother	___	________________________	____
Biological Father	___	________________________	____
Step/Adoptive father	___	________________________	____
Brothers	___	________________________	____
	___	________________________	____
	___	________________________	____
Sisters	___	________________________	____
	___	________________________	____
	___	________________________	____

If your parents are deceased, please indicate your age at the time of their death(s): ___________________________________

M. ROLES/RELATIONSHIPS

1. Marital status (please check one):

   ___single ___married ___living in a committed relationship

   ___separated ___divorced ___widowed (if so, how long?) : ____________

   (If single go to question 3)

2. How many times have you been married? __________

   Dates of current marriage: From _________ to __________ Your age at time of this marriage: ______

   Describe your marriage:____

3. Number of biological/adopted children? ______ Ages/Gender _________________________________

   Number of stepchildren? _____ Ages/Gender____

   How many children living at home? ________

4. How many people live in your household? ________________

5. Do you have pets? Please list.____

6. Your occupation: ________________________ Hours worked/week: ________________________

   How satisfied are you with your job/career? ___very satisfied ___satisfied ___dissatisfied

N. SUBSTANCE USE

1. Do you smoke cigarettes? ____yes _____no If yes, how many cigarettes per day? ____ How many years? _____
2. If no, did you ever smoke? ____yes ____no How many cigarettes a day? ____ Date of last cigarette?___________

3. If you drink alcohol at least once a month, please estimate how much:

   ________wine (glasses/week) _______beer (glasses/week) _______alcohol (oz/week)

4. Do you now or have you ever used recreational drugs? ___yes ____no

   Describe ____