CLEARWAY℠
PAIN SOLUTIONS INSTITUTE

PATIENT HISTORY INDEX (ORT)

Please complete as directed. This will help your Doctor in the evaluation process.

Patient Name _____ Patient DOB _____ Today's Date _____

1. Family History of Substance Abuse:

Mark each box that applies

Alcohol ❑ Yes ❑ No
Illegal Drugs ❑ Yes ❑ No
Prescription Drugs ❑ Yes ❑ No

2. Personal History of Substance Abuse:

Alcohol ❑ Yes ❑ No
Illegal Drugs ❑ Yes ❑ No
Prescription Drugs ❑ Yes ❑ No

3. Age (mark box if between 16-45): ❑ Yes ❑ No

4. History of Childhood Trauma (physical or sexual abuse): ❑ Yes ❑ No

5. Psychological Disease:

Attention Deficit Disorder ❑ Yes ❑ No
Obsessive-Compulsive Disorder ❑ Yes ❑ No
Bipolar Disorder ❑ Yes ❑ No
Schizophrenia ❑ Yes ❑ No
Depression ❑ Yes ❑ No

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1. Do you have sleep apnea? ❑ Yes ❑ No
2. Do you have COPD? ❑ Yes ❑ No
3. Do you drink alcohol daily? ❑ Yes ❑ No
4. Do you currently smoke two or more packs per day? ❑ Yes ❑ No
5. Does your family and care givers understand your pain? ❑ Yes ❑ No

If No, explain: _____

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