PainCare
manage pain • improve life

Revised 11/21/2011

Name ______________________________ **Date** ______________

Email Address______________________________

Referred by ____________________ **Primary Care Doctor** ____________________

Reason for today's visit ______________________________

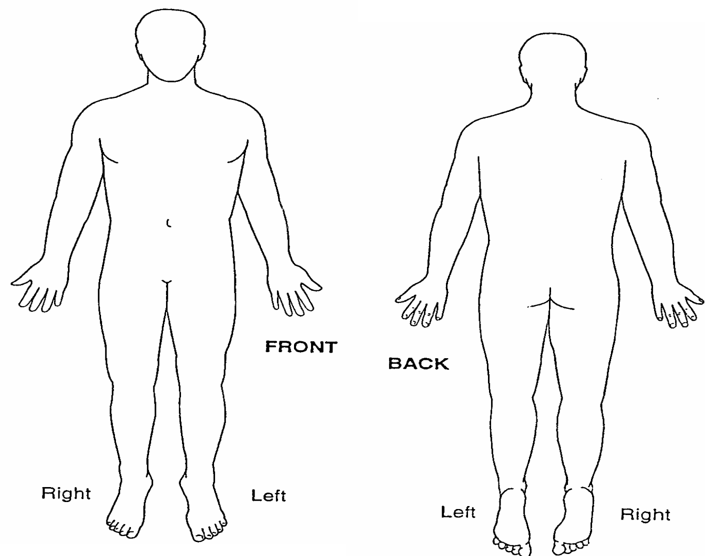
Emergency Contact____________________ (H) Phone ____________ (C) ____________

Do you want medical information to be shared with this person? Yes _____ No _____ If No, Is there someone you would like us to share information with? ____________________ What is their relationship to you? ____________

PAIN TREATMENT HISTORY

PAIN:	Location 1	Location 2	Location 3
Where is your pain?			
When did it start?			
How did it begin? (suddenly, gradually, injury, at work, fall, etc.)			
What does it feel like? (burning, aching, sharp, dull, shooting, etc.)			

Please draw on the diagram where your pain is located.



(Circle one)

Pain level now? (0=no pain, 10= worst imaginable pain)	0	1	2	3	4	5	6	7	8	9	10
Average pain level over the last month	0	1	2	3	4	5	6	7	8	9	10
Lowest that it has been in the last month or two	0	1	2	3	4	5	6	7	8	9	10
Highest that it has been in the last month or two	0	1	2	3	4	5	6	7	8	9	10

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(**Please circle <u>all</u> that apply)**

What aggravates your pain?	heat | cold | activity | driving | lying down | sitting | standing | walking bending | lifting | weather | prolonged positions | stress
What relieves your pain?	heat | cold | activity | rest | lying down | sitting | standing | walking massage | changing positions | stretching | medication
Associated signs & symptoms:	problems sleeping | depression | anxiety | decreased range of motion | sexual issues difficulty urinating | saddle anesthesia | bowel or bladder dysfunction | numbness or tingling
Pain is worse in:	morning | afternoon | evening | night
Pain is:	continuous | intermittent

Please list any diagnostic tests, x-rays, etc. you have had.

TEST	**X-RAY**	**CT SCAN**	**MRI SCAN**	**EMG**	**OTHER**
WHEN					
WHERE					

List medications TRIED for pain and their effectiveness:

Medication:	**Effect:**	**Medication:**	**Effect:**

Use reverse side to list additional medications

What other types of treatments have you tried and were they effective?

Treatment:	**Effective?**	**Treatment:**	**Effective?**

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What other providers have you seen for pain?
(Please include other pain clinics, specialists, and primary providers) **Use reverse side to list additional providers**

Provider Name ______________________________
Clinic Name ______________________________
Address ______________________________
Phone ______________________________
Are you still a patient? Y__ N__
Have you been seen in the last 2 yrs? Y__ N__

Provider Name ______________________________
Clinic Name ______________________________
Address ______________________________
Phone ______________________________
Are you still a patient? Y__ N__
Have you been seen in the last 2 yrs? Y__ N__

Provider Name ______________________________
Clinic Name ______________________________
Address ______________________________
Phone ______________________________
Are you still a patient? Y__ N__
Have you been seen in the last 2 yrs? Y__ N__

Provider Name ______________________________
Clinic Name ______________________________
Address ______________________________
Phone ______________________________
Are you still a patient? Y__ N__
Have you been seen in the last 2 yrs? Y__ N__

MEDICATIONS AND ALLERGIES

Please list ALL CURRENT medications:

Medication / Strength	Dosage / Frequency	Medication / Strength	Dosage / Frequency

Please list all allergies below: ☑ **Check which reactions you've had.**

Allergy:	Nausea / vomiting	Rash	Difficulty breathing	Other: ____________

**Include medications, latex, tape, food, environmental, etc.

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SOCIAL HISTORY

If yes, circle below:

Marital Status	M D S W	
Are you pregnant?	Yes / No	
Do you have children?	Yes / No	If Yes, how many?
Do you live alone?	Yes / No	
Do you have any animals?	Yes / No	If Yes, how many?
Education: last grade completed	9-10-11-12	Some College Associates Degree Bachelors Degree Graduates Degree
Any legal actions related to a pain condition?	Yes / No	Explain:
Are you working?	Yes / No	Occupation?
Are you disabled?	Yes / No	Reason?
What are your hobbies?		

If applicable, amount?

Do you smoke?	Yes / No	Cigarettes / cigars / chew	Per day
Do you drink alcohol?	Yes / No	Beer / wine / liquor	Per day
Do you drink caffeinated beverages?	Yes / No		Per day
Any present illicit drug use?	Yes / No	Marijuana / cocaine / heroin / illicit Rx. / other	
Any past illicit drug use?	Yes / No	Marijuana / cocaine / heroin / illicit Rx. / other	
Have you ever had an eating disorder?	Yes / No	When?	
Do you exercise?	Yes / No		Per week:

SURGICAL HISTORY

Please list <u>all</u> past surgeries/operations: <u>Use reverse side to list additional surgeries</u>

Type of operation	Date	Type of operation	Date

MEDICAL AND MENTAL HEALTH HISTORY

Please list <u>all</u> medical and psychiatric hospitalizations: <u>Use reverse side to list additional hospitalizations</u>

Name of facility	Reason	Date

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ILLNESSES

Please check ☑ any of the following that you have or have had in the past?

night sweats		abnormal thirst		chronic bronchitis	
fever		weak urine stream		pneumonia	
chills		difficulty urinating		tuberculosis	
fatigue		black stool		muscle/joint disease	
chronic cough		heart murmur		diabetes	
palpitations		rheumatic fever		hepatitis	
light headedness		heart attack		urinary infection	
swelling of limbs		high blood pressure		depression	
bleeding		blood transfusion		seizures/ convulsions	
dizziness		bleeding disorder		eating disorders	
tremors		anemia		anxiety/panic disorder	
headaches		stroke		other psychiatric disease	
rashes		Parkinson's disease		serious injury	
chest pain		dementia		cancer	
shortness of breath		emphysema		sexually transmitted disease	
heartburn		asthma		HIV/AIDS	
Other:					

FAMILY HISTORY

Family History (blood relatives): Please check ☑ all that apply.

	Father	Mother	Siblings	Children	Other Relatives	Spouse or significant other
Age at death						
Cause of death						
Heart disease/stroke						
High blood pressure						
Diabetes						
Cancer						
Epilepsy						
Nervous breakdown						
Asthma, hives, hay fever						
Blood disease						
Chronic pain						
Other:________________						