

Name: _____

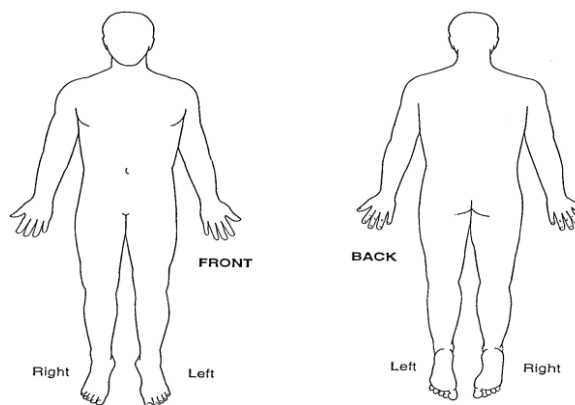
Date of Birth: ____/____/____

Reason for today's visit: _____

PAIN TREATMENT HISTORY

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

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

(Please circle all 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 | sexual issues
decreased range of motion | 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:

What types of treatments have you tried and were they effective? (Ex. Physical therapy, acupuncture, chiropractor, etc.)

Treatment:	Effective?	Treatment:	Effective?

What other providers have you seen for pain? (Include other pain clinics, specialists, and primary providers)

- 1) **Provider Name:** _____ **Office Name:** _____
 Address: _____ Phone: _____
Are you still a patient? Yes / No **If yes, have you been there in the last 2 years?** Yes / No
- 2) **Provider Name:** _____ **Office Name:** _____
 Address: _____ Phone: _____
Are you still a patient? Yes / No **If yes, have you been there in the last 2 years?** Yes / No
- 3) **Provider Name:** _____ **Office Name:** _____
 Address: _____ Phone: _____
Are you still a patient? Yes / No **If yes, have you been there in the last 2 years?** Yes / No
- 4) **Provider Name:** _____ **Office Name:** _____
 Address: _____ Phone: _____
Are you still a patient? Yes / No **If yes, have you been there in the last 2 years?** Yes / No

CURRENT MEDICATIONS

Name of Medication	Strength (ex. 500 mg)	Dosing Instructions (ex. Twice a day)

ALLERGY HISTORY

No Known Allergies Medication Allergies Environmental/Seasonal Allergies Latex Allergies

Allergen (ex. Food, Dust, Animals, Pollen, Medication)	Reaction (ex. Rash, nausea, respiratory, shock, etc.)

SOCIAL HISTORY (Please circle all applicable responses)

Marital Status	Single	Significant Other	Married	Divorced	Widowed		
Living Situation	Alone	Spouse/Significant other	Children/Family	Other			
Females- Are you pregnant?	Yes / No	Hysterectomy	Menopause	Tubal ligation			
Do you have children?	Yes / No	If yes, how many?					
Education (highest level)	9	10	11	12	Some college	Associates	Bachelors
		GED				Masters	PhD
Are you working?	Yes / No	If yes, occupation?					
Are you disabled?	Yes / No	If yes, reason?					
Any legal actions related to a pain condition?	Yes / No	Explain:					

If applicable, amount?

Tobacco Use?	Yes / No	Cigarettes / Cigars / Chew	Per day:
<i>If no, have you ever?</i>	Yes / No	Cigarettes / Cigars / Chew	Per day:
Do you drink alcohol?	Yes / No	Beer / Wine / Liquor	Per day:
Do you drink caffeine?	Yes / No	Coffee / Tea / Soda / Energy Drink	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	
Do you exercise?	Yes / No	Type?	Per week:
Do you wear your seatbelt?	Yes / No	If yes, percent of time:	
Do you have Advanced Directives in place?	Yes / No	Living Will	Durable Power of Attorney
		Health Care Proxy	Advanced Directives

MEDICAL HISTORY (Please check any of the following that you have or have had in the past)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dementia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Glaucoma/Cataracts | <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Other: _____ |

FAMILY HISTORY (Please tell us about the health of your immediate family)

	Father	Mother	Siblings	Children	Other
Age at Death					
Cause of Death					
Heart Disease/ Stroke					
High Blood Pressure					
Diabetes					
Cancer (type)					
Epilepsy/Seizures					
Asthma					
Blood Disease					
Other:					

SURGICAL HISTORY (Please list all past surgeries/operations):

Type of Operation	Date	Type of Operation	Date

MEDICAL AND MENTAL HEALTH HISTORY (Include all injuries or hospitalizations):

Name of Facility	Reason	Date