**DATE: \_\_\_\_ \_\_\_\_\_\_HT: \_ \_\_\_\_\_ WT: \_\_ \_\_\_\_\_ BP: \_\_\_\_\_ \_\_\_\_ TEMP: \_\_\_**

# PATIENT HISTORY INFORMATION

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_**

**REFERRAL DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRIMARY CARE PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Please list pharmacy you would like to have on file:

**Please list any medication allergies:**

**PAIN QUESTIONARE**

Circle the areas of pain. Mark an “X” in areas of numbness.

**When did the pain start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_**

**Where do you feel the most pain?**

mostly back mostly leg R/L both back and leg mostly neck mostly arm R/L neck and arm other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle your current pain level:**

0 1 2 3 4 5

6 7 8 9 10

**At its best: \_\_\_\_\_\_ At its worst: \_\_\_\_\_\_**

**Would you describe your pain as:**

 dull sharp burning shooting electric other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have weakness?**  yes no

**If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any of the following sensations in your extremities?**  numbness tingling burning other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any disturbance of:**  bowel bladder sexual function

**Is current pain related to a previous injury/trauma? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do any of the following increase your pain?**

## **Coughing Sneezing Straining Sitting Lifting Twisting Standing Stress Cold Walking Sleeping on stomach/back other\_\_\_\_\_\_\_\_\_\_**

## How many hours do you sleep in a typical night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does your pain affect your sleep?  yes  no

**What other doctors have you seen for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently working?**  yes no **If no explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is this an active Workers Compensation Case?**  yes no **If yes Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you hired an attorney because of this injury?**  yes no If yes, who? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please check the following for pain interferences.**

 General Activity/Daily Living (bathing, cooking, chores, etc.) Mood Walking ability

Relationships with other people Enjoyment of Life other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any of the following you have tried to control your pain.**

Medications Physical/Aquatic Therapy Chiropractor Acupuncture Massage Therapy Hot/Cold Therapy TENS Unit

**Circle any of the following problems you are dealing with.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **General** | **Musculoskeletal** | **Dermatology** | **HEENT** | **Respiratory** |
| Change in Appetite | Arthralgia’s (joint pain) | Hives | Blurred Vision | Cough |
| Fatigue | Crepitus (joint popping) | Infection | Glaucoma R/L | Hemoptysis (Coughing Blood) |
| Fever/Chills | Deformity | Jaundice | Cataracts R/L | Shortness of Breath |
| Night Sweats | Muscle Loss | Rash | Dry Mouth |  |
| Weight Gain | Stiffness |  | Headache |  |
| Weight Loss |  |  | Vertigo |  |
|  |  |  | Deafness |  |
| **Cardiology** | **Gastroenterology** | **Genitourinary** | **Neurology** | **Endocrinology** |
| Chest Pain | Abdominal Pain | Change in Urinary Habit | Dizziness | Diabetes |
| Edema (Swelling) | Change in Bowel Habits | Increased Frequency | Numbness | Thyroid Problems |
| Palpitations | Constipation | Hematuria | Seizures |  |
|  | Diarrhea | Incontinence | Tingling | **Psychology** |
|  | Fecal Incontinence | UTI | Weakness | Anxiety |
|  | Nausea |  | History of Stroke | Depression |
|  | Vomiting |  |  | Suicidal Ideation |

**Please mark an (X) for any of the following medical conditions you have.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medical History**  | **Yes** |  **No** | **Medical History** | **Yes** |  **No** |
| Hypo/Hyper Thyroidism |  |  | Diabetes Type 1/2 |  |  |
| HIV/AIDS |  |  | High Cholesterol |  |  |
| Carpal Tunnel Syndrome |  |  | High Lipids |  |  |
| Migraines |  |  | Hypertension |  |  |
| Coronary Artery Disease |  |  | Bleeding Problems |  |  |
| Cancer |  |  | Rheumatologic Disorders |  |  |
| COPD |  |  | Asthma |  |  |
| GERD |  |  | Heart Attack |  |  |
| Peripheral Vascular Disease |  |  | Blood Clots |  |  |
| Sleep Apnea |  |  | GI Ulcers |  |  |
| Osteoarthritis/Osteoporosis |  |  | Kidney Problems |  |  |
| Other: |  |  | Liver Problems (Hepatitis) |  |  |

|  |  |  |
| --- | --- | --- |
| Abdominal Surgery | Hernia Repair: Umbilical/Inguinal | Cesarean Section (C-Section) |
| Tonsillectomy/Adenoidectomy | Hip Replacement R/L | Knee Surgery |
| Amputation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Hysterectomy | Radiofrequency Ablation |
| Appendectomy | Knee Replacement R/L | Spinal Cord Stimulator |
| Arthroscopy  | Kidney Surgery | Pain Pump |
| Back Surgery | Neck Surgery | Shoulder Surgery |
| Carpal Tunnel Release | Cholecystectomy | Pacemaker |
| Colon Surgery | Thyroidectomy | Gastric Bypass Surgery |
| Transplant | Other:  |

**Please circle past surgeries:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Do you drink Alcohol?** | **Do you Smoke?** | **Do you use Illicit drugs?** | **Marital Status** | **Activities and Hobbies** | **Disability?** |
|  yes noHow much? \_\_\_\_\_\_\_ |  yes noHow long? \_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_  |  yes noMarijuana, cocaine, other\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Single MarriedOther:\_\_\_\_\_\_\_\_ | List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  yes  no |

**Please mark an (X) for any of the following:**

**Please mark an (X) for any of the**

|  |  |  |
| --- | --- | --- |
| **Family History** | **Mother** | **Father** |
| Cancer |  |  |
|  Type: |  |  |
| Heart Disease |  |  |
| Back / Neck pain |  |  |
| Diabetes |  |  |
| Migraines |  |  |
| High Blood Pressure |  |  |
| Rheumatoid Arthritis |  |  |
| Neurologic Disorder |  |  |
|  Type: |  |  |
| Other |  |  |

**following family medical history:**

**Are you allergic to x-ray or contrast dye?**  yes no **Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List all medications along with prescribing doctor and dose (including blood thinners):**

**What are your expectations/goals in being treated with Pain Management?**