

Pain Medical History

Date: _____ Referred By: _____ Family Doctor: _____

Patient Name: _____ Date of Birth: _____

Preferred Name: _____ Preferred Pharmacy: _____

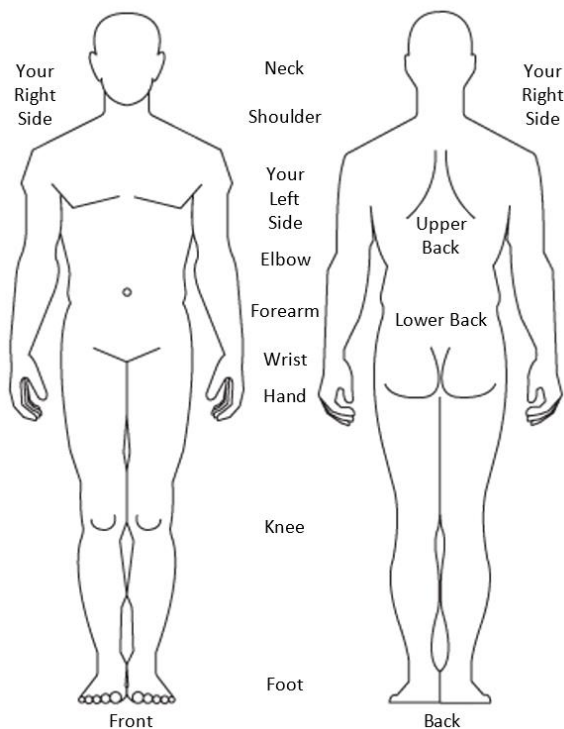
Age: _____ Height: _____ Weight: _____ Advanced Directive? YES NO

CHIEF COMPLAINT:

Location of pain: _____ Date of Onset: _____

Pain Radiates From / To: _____

Does the pain radiate: Equal Intensity **OR** One Location More Severe: _____



Please mark your pain on the above body

How did symptoms occur?

- No Injury – suddenly
- No injury – gradually
- Auto Accident
- Sports Accident
- Injury at Work
- Prior Surgery

Current Pain Level (from 0-10): _____

Pain Level at Worst (From 1-10): _____

What are your symptoms?

- Numbness or Tingling
- Radiating Pain
- Spasms
- Stiffness
- Weakness
- Other: _____

Do you experience any of the following?

- Balance Issues
- Bladder Incontinence
- Bowel Incontinence
- Unsteadiness when walking
- None of the above

What makes the symptoms worse?

- All Activities
- Bending
- Changing Position
- Coughing
- Driving
- Lifting
- Sitting
- Standing
- Twisting
- Walking
- Sleeping
- Other: _____

What treatment have you tried?

- | | | |
|--|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Activity Modification | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Bracing | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> NSAIDS | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Prescription Pain Medications | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Topical Creams | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Chiropractic Therapy | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Steroid Injections | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Improved | <input type="checkbox"/> Worsened |

Have you had any prior tests for this problem?

- | | |
|---|---|
| <input type="checkbox"/> No Imaging Studies | <input type="checkbox"/> Nerve Test (EMG) |
| <input type="checkbox"/> X-Rays | <input type="checkbox"/> Bone Scan |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> MRI | |

What is your current work status?

- Disabled
- Retired
- Working a reduced schedule
- Working full time with out restrictions
- Working with restrictions

What is your occupation? _____

Who referred you?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Another Patient | <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Primary Care Provider | <input type="checkbox"/> Urgent Care Provider |
| <input type="checkbox"/> Self Referred | <input type="checkbox"/> Internist | <input type="checkbox"/> Therapist | <input type="checkbox"/> Workmans Compensation |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Trainer | <input type="checkbox"/> Other: _____ |

PAST MEDICAL HISTORY

Past Medical Conditions:

- | | | |
|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Disease caused by COVID19 | <input type="checkbox"/> Malignant Lymphoma |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> End-Stage Renal Disease | <input type="checkbox"/> Malignant Tumor of Colon |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Obstructive Sleep Apnea Syndrome |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Essential Hypertension | <input type="checkbox"/> Primary Fibromyalgia Syndrome |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> GERD | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cerebrovascular Accident | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Type 2 Diabetes Mellitus |
| <input type="checkbox"/> COPD | <input type="checkbox"/> History of Radiation Therapy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> HIV | |
| <input type="checkbox"/> Deep Venous Thrombosis | <input type="checkbox"/> High Cholesterol | |
| <input type="checkbox"/> Depressive Disorder | <input type="checkbox"/> Ischemic Heart Disease | |
| <input type="checkbox"/> Diabetic on Insulin | <input type="checkbox"/> Leukemia | |

Past Surgeries:

- | | | |
|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Bypass of Stomach | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Mechanical Heart Valve Replacement |
| <input type="checkbox"/> Cholecystectomy (Gallbadder) | <input type="checkbox"/> Colectomy | <input type="checkbox"/> Prostatectomy |
| <input type="checkbox"/> Coronary Artery Bypass Graft | <input type="checkbox"/> Tissue Graft Heart Valve Replacement | <input type="checkbox"/> Repair of Aneurysm |
| <input type="checkbox"/> Cataract | | <input type="checkbox"/> Tonsillectomy |
| | | <input type="checkbox"/> Other: _____ |

Musculoskeletal Disease History

- | | | |
|--|---|---|
| <input type="checkbox"/> None/Unknown | <input type="checkbox"/> Complex Regional Pain Syndrome | <input type="checkbox"/> Hip Fracture |
| <input type="checkbox"/> Adhesive Capsulitis of Shoulder | <input type="checkbox"/> Compression Fracture of Vertebral Column | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Epidural Steroid Injection | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bursitis | | <input type="checkbox"/> Idiopathic Scoliosis |
| <input type="checkbox"/> Carpal Tunnel Syndrome | | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Chronic Low Back Pain | | <input type="checkbox"/> Cervical Spinal Stenosis |
| | | <input type="checkbox"/> Lumbar Spinal Stenosis |

Musculoskeletal Surgical History:

- | | |
|--|---|
| <input type="checkbox"/> Decompression of Lumbar Spine | <input type="checkbox"/> Kyphoplasty: Levels _____ |
| <input type="checkbox"/> Decompression of Median Nerve (Carpel Tunnel Release) | <input type="checkbox"/> Lumbar Spinal Fusion: Levels _____ |
| <input type="checkbox"/> Lumbar Laminectomy | <input type="checkbox"/> Osteotomy and Discectomy of Cervical Spine |
| <input type="checkbox"/> History of Arthroplasty R_____ L_____ | <input type="checkbox"/> Hip Replacement R_____ L_____ |
| <input type="checkbox"/> History of Arthroscopy of Knee Joint | <input type="checkbox"/> Total Shoulder R_____ L_____ |
| <input type="checkbox"/> Rotator Cuff Repair of Shoulder | |

List of Medications: _____

Latex Allergy: Yes No

Do you have any Allergies? Yes No If Yes, please list: _____

SOCIAL HISTORY:

Do you smoke? Daily Occasionally Former Smoker Never

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____

Do you drink alcohol? None < 1 Drink / Day 1-2 Drinks / Day 3 or more Drinks / Day

How often do you exercise?
 Never Once a Day Several Times a Day Few Time a Week Few Times a Month

REVIEW OF SYSTEMS:

Please indicate if you have experienced any of the following symptoms in the past six months:

None for all _____

- | | | | | | |
|---------------------------------|-------------------------------|-------------------|-----------------------|------------------|---------------|
| <input type="checkbox"/> CON | Fatigue | Weight Loss | Fever | Chills | Weight Gain |
| <input type="checkbox"/> EYE | Redness | Corrective Lenses | Blurred Vision | | |
| <input type="checkbox"/> ENT | Nose Bleeds | Ringing in Ears | Hoarseness | | |
| <input type="checkbox"/> CARDIO | Chest Pain | Palpitations | Fainting | Heart Murmur | Leg Cramps |
| <input type="checkbox"/> RESP | Shortness of Breath | Wheezing | Cough | Hurts to Breathe | |
| <input type="checkbox"/> GI | Heartburn | Nausea/Vomiting | Constipation | Diarrhea | Bloody Stools |
| <input type="checkbox"/> GU | Frequent Urination | Painful Urination | Incontinence | Blood in Urine | |
| <input type="checkbox"/> SKIN | Poor Healing Wounds | Rash | Itching | Scarring | |
| <input type="checkbox"/> NEURO | Numbness | Tingling | Dizziness | Headaches | Tremors |
| <input type="checkbox"/> PSYCH | Nervousness | Anxiety | Depression | Hallucinations | |
| <input type="checkbox"/> ENDO | Excessive Thirst or Urination | | Heat/Cold Intolerance | | |
| <input type="checkbox"/> HEM | Easy Bleeding | Easy Bruising | | | |
| <input type="checkbox"/> MUSC | Joint Pain | Joint Swelling | Joint Stiffness | Unsteady Gait | |

Mark All That Apply:

- Metal in Body
 Claustrophobic
 Pregnant
 Pacemaker
 Defibrillator
 Allergy to Shellfish/Iodine
 Allergy to Latex
 Allergy to Adhesive

Are you taking a blood thinner? Yes No

Please list provider who prescribes blood thinner: _____

FAMILY HISTORY:

Please list relation next to family history:

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Epilepsy: _____ |
| <input type="checkbox"/> Diabetes: _____ | <input type="checkbox"/> Osteoporosis: _____ |
| <input type="checkbox"/> Heart Disease: _____ | <input type="checkbox"/> Stroke: _____ |
| <input type="checkbox"/> Hypertension: _____ | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Bleeding Problems: _____ | <input type="checkbox"/> Rheumatoid Arthritis: _____ |
| | <input type="checkbox"/> Muscular Dystrophy: _____ |
| | <input type="checkbox"/> Other: _____ |

DURING THE LAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY LITTLE INTEREST OR PLEASURE IN DOING THINGS?

NOT AT ALL SEVERAL DAYS MORE THAN HALF THE DAYS NEARLY EVERY DAY

DURING THE PAST TWO WEEKS, HAVE YOU OFTEN BEEN BOTHERED BY FEELING DOWN, DEPRESSED, OR HOPELESS?

NOT AT ALL SEVERAL DAYS MORE THAN HALF THE DAYS NEARLY EVERY DAY