MD PAIN

Pain Medical History

Date:_____ Referred By:_____ Family Doctor:_____

Patient Name:_____ Date of Birth:_____

Preferred Name:_____ Preferred Pharmacy:_____

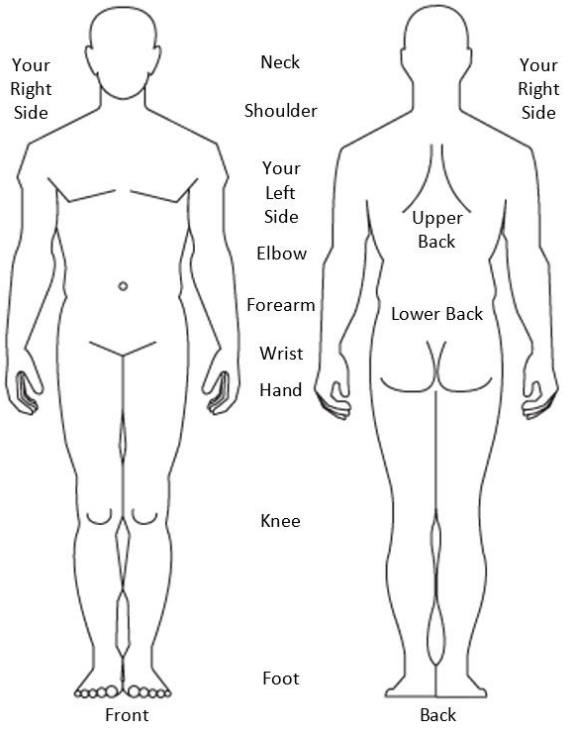
Age: _____ Height:_____ Weight:_____ Advanced Directive? YES☐ NO☐

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?

☐ Rest	☐ Improved	☐ Worsened
☐ Acitivity Modification	☐ Improved	☐ Worsened
☐ Bracing	☐ Improved	☐ Worsened
☐ Cold	☐ Improved	☐ Worsened
☐ Heat	☐ Improved	☐ Worsened
☐ Muscle Relaxants	☐ Improved	☐ Worsened
☐ NSAIDS	☐ Improved	☐ Worsened
☐ Prescription Pain Medications	☐ Improved	☐ Worsened
☐ Topical Creams	☐ Improved	☐ Worsened
☐ Tylenol	☐ Improved	☐ Worsened
☐ Physical Therapy	☐ Improved	☐ Worsened
☐ Chiropractic Therapy	☐ Improved	☐ Worsened
☐ Massage	☐ Improved	☐ Worsened
☐ Steroid Injections	☐ Improved	☐ Worsened
☐ Surgery	☐ Improved	☐ Worsened
☐ Other:_____	☐ Improved	☐ Worsened

Have you had any prior tests for this problem?

- ☐ No Imaging Studies
- ☐ X-Rays
- ☐ CT Scan
- ☐ MRI
- ☐ Nerve Test (EMG)
- ☐ DEXA
- ☐ Other:_____

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?

- ☐ Another Patient
- ☐ Self Referred
- ☐ Chiropractor
- ☐ Emerency Room
- ☐ Internist
- ☐ Pain Management
- ☐ Primary Care Provider
- ☐ Therapist
- ☐ Trainer
- ☐ Urgent Care Provider
- ☐ Workmans Compensation
- ☐ Other:_____

PAST MEDICAL HISTORY

Past Medical Conditions:

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

Past Surgeries:

- ☐ None
- ☐ Bypass of Stomach
- ☐ Cholecystecomy (Gallbadder)
- ☐ Coronary Artery Bypass Graft
- ☐ Cataract
- ☐ Hernia Repair
- ☐ Appendectomy
- ☐ Colectomy
- ☐ Tissue Graft Heart Valve Replacement
- ☐ Hysterectomy
- ☐ Mechanical Heart Valve Replacement
- ☐ Prostatectomy
- ☐ Repair of Aneurysm
- ☐ Tonsillectomy
- ☐ Other:_____

Musculoskeletal Disease History

- ☐ None/Unknown
- ☐ Adhesive Capsulitis of Shoulder
- ☐ Ankylosing Sponsylitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Complex Regional Pain Syndrome
- ☐ Compression Fracture of Vertebral Column
- ☐ Epidural Steroid Injection
- ☐ Hip Fracture
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Idiopathic Scoliosis
- ☐ Osteoarthritis
- ☐ Cervical Spinal Stenosis
- ☐ Lumbar Spinal Stenosis

Musculoskeletal Surgical History:

- ☐ Decompression of Lumbar Spine
- ☐ Decompression of Median Nerve (Carpel Tunnel Release)
- ☐ Lumbar Laminectomy
- ☐ History of Arthroplasy R_____ L_____
- ☐ History of Arthroscopy of Knee Joint
- ☐ Rotator Cuff Repair of Shoulder
- ☐ Kyphoplasty: Levels_____
- ☐ Lumbar Spinal Fusion: Levels_____
- ☐ Osteotomy and Discectomy of Cervial Spine
- ☐ Hip Replacement R_____ L_____
- ☐ Total Shoulder R_____ L_____

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

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REVIEW OF SYSTEMS:

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

None for all_____

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

☐ None
☐ Diabetes:_____
☐ Heart Disease:_____
☐ Hypertension:_____
☐ Bleeding Problems:_____
☐ Epilepsy:_____
☐ Osteoporosis:_____
☐ Stroke:_____
☐ Cancer:_____
☐ Rheumatoid Arthritis:_____
☐ Muscular Dystrophy:_____
☐ 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