

PAIN HISTORY FORM

TODAY'S DATE _____
NAME _____ How would you like to be addressed? _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
AGE _____ DATE OF BIRTH _____ GENDER _____ SS# _____
HOME# _____ WORK# _____ CELL# _____
MARITAL STATUS _____ HOW MANY CHILDREN DO YOU HAVE _____
OCCUPATION _____
EMERGENCY CONTACT _____ PHONE# _____
DO YOU SMOKE _____ HOW MUCH _____
DO YOU EXERCISE _____ HOW OFTEN _____ TYPE _____
WHICH HAND DO YOU WRITE WITH? RIGHT _____ LEFT _____
REFERRING PHYSICIAN _____

1. **WHERE** are your complaints?

<input type="checkbox"/> Neck	<input type="checkbox"/> Chest or Abdomen	<input type="checkbox"/> Calf R / L
<input type="checkbox"/> Shoulder R / L	<input type="checkbox"/> Low Back	<input type="checkbox"/> Ankle R / L
<input type="checkbox"/> Arm R / L	<input type="checkbox"/> Buttock	<input type="checkbox"/> Foot R / L
<input type="checkbox"/> Hand R / L	<input type="checkbox"/> Hip R / L	<input type="checkbox"/> Entire Leg R / L
<input type="checkbox"/> Mid or Upper Back	<input type="checkbox"/> Thigh R / L	<input type="checkbox"/> Tailbone
<input type="checkbox"/> Headaches	<input type="checkbox"/> Knee R / L	

2. **WHEN** did your symptoms start? Approximate Date: _____

3. Any **PREVIOUS** episodes of this problem **PRIOR** to now?

No
 Yes / Explain: _____

4. How did your pain / problem begin?

Gradually Suddenly

5. **WHAT** were you **DOING** at the time of your pain onset?

<input type="checkbox"/> Nothing	<input type="checkbox"/> Bending	<input type="checkbox"/> Hit on the back
<input type="checkbox"/> Sports	<input type="checkbox"/> Pulling	<input type="checkbox"/> Fell (how far? _____ feet
<input type="checkbox"/> Lifting	<input type="checkbox"/> Pushing	How did you land? _____
<input type="checkbox"/> Twisting		_____)
		<input type="checkbox"/> Woke up in bed with pain
		<input type="checkbox"/> other; Explain _____

6. In the last 6 months my **PAIN PATTERN** has been:

A single attack of pain
 Attacks of pain with **pain-free intervals**
 Continuous pain
 Other - Explain: _____

7. How long does a **PAIN ATTACK** last?

Minutes Hours Days Weeks Consistent

8. Does your **PAIN LOCATION** seem to move or change location?

Yes No

9. Do you have any **OTHER PHYSICAL PROBLEMS** that restrict your activity?

No Yes Explain: _____

10. What makes your pain **BETTER**?

Bed rest (any position) Exercise or Activity Sitting Medication
 Standing Walking Heat Cold
 Changing positions Chiropractor Brace Traction
 Physical Therapy Nothing

11. Do you require any **WALKING AIDS**?

Wheelchair Cane Walker Crutches

When did you **START** using the walking aid?

Days, Weeks, Months, Years Ago

When do you **USE** it?

In home Out of home Always

12. Are you currently:

Working full time? Working part time? Disabled, temporarily?

Disabled, permanently? Unemployed Retired?

Other - Explain _____

13. Have you applied for Social Security Benefits?

Yes No

Is there Workman's Compensation involved?

Yes No

Is there a lawsuit pending? Yes

No

14. How many months have you worked at your present job?

Less than **6** months

More than **6** months

15. How does your pain affect your **SLEEP**?

Not at all Mildly: Difficulty falling asleep Greatly: Sleep only 3-5 hours

16. If you have trouble falling asleep, do you have **MORE** trouble:

Falling asleep Waking up during the night or in the early morning

17. When is the **WORST** time of day, due to pain?

Mornings Afternoons Evenings Nights

18. How much of the day (hours) do you spend "down"; i.e. in bed, recliner, or couch - due to pain?

None 0-2 hours 2-4 hours "Down" **half** the time "Down" **most** the time

19. How many times have you been to the Emergency Room, MEC, etc. for your pain? _____

When? _____

20. Have you been **hospitalized** for your back/neck pain? No Yes

How many times? _____ When? _____

21. Have you seen a **physical therapist** for your back/neck pain? No Yes

Where? _____

When? From _____ To _____

Did it help: Pain? No Yes

Function? No Yes

22. List all physicians/doctors who have seen for this problem or related issue:

WHO?	SPECIALTY?	WHEN?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

23. List all **TESTS/PROCEDURES** previously performed for the problem we are seeing you for today:

TEST	WHEN (approximate)	RESULT
_____ X-Rays	_____	_____
_____ CT or CAT Scan	_____	_____
_____ Facet Block	_____	_____
_____ Epidural	_____	_____
_____ MRI	_____	_____

24. Do you take any medications including over the counter drugs or supplements? _____

Name of Medication	Dose	How often Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

25. Do you have any allergies such as food, medicine and/or chemical? _____

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

26. Please check any that apply to your past medical, surgical or family history.

<u>Medical Problems</u>	How long?	Surgical History (Dates):
High Blood Pressure	_____	_____
Lung Disease	_____	_____
Bleeding Problems	_____	_____
Diabetes	_____	_____
Stroke	_____	_____
Heart Disease	_____	_____
Cancer	_____	_____
Thyroid	_____	_____
Obesity	_____	_____
Fibromyalgia	_____	_____