

Initial Visit Patient History

PAIN MANAGEMENT

Date of Appointment:

Physician:

Date: Your Name:

Referring Physician: Family Physician:

Other doctors seen for this condition:

Result of Accident? Yes No

Work related? Yes No

Previous work related injuries? Neck Back Other

Do you have a lawyer for this injury? Yes No

Name of lawyer:

Are you receiving compensation or disability payments now? Yes No

Do you have compensation or disability payments pending? Yes No

CURRENT PROBLEM

Age: L or R Handed Sex: *M / F*

Chief Complaint:

Where do you hurt?

How did your pain start?

When did your pain start? Month Day Year

Have you had similar symptoms before? If so, when?

CHARACTERISTICS OF PAIN

Pain Score: On a scale of 0-10. 0=No pain 10=worst pain you can imagine

Your pain score at its **BEST** is: at its **WORST** is: **AVERAGE**:

Are any of these symptoms associated with your pain?

- numbness* _____
- weakness* _____
- loss of bladder control* _____
- loss of bowel control* _____

When is your pain worse?

- morning* _____
- afternoon* _____
- evening* _____
- no typical pattern* _____

Check the **one word in each column** that best describes your average pain in the past month.

Intensity

- Excruciating
- Extremely strong
- Very strong
- Strong
- Moderate
- Mild
- Weak
- Very weak
- Just noticeable
- None
- Variable

Reaction

- Intolerable
- Miserable
- Distressing
- Uncomfortable
- Tolerable
- None

Sensation

- Piercing
- Stabbing
- Shooting
- Burning
- Grinding
- Throbbing
- Cramping
- Aching
- Stinging
- Squeezing
- Numbing
- Itching
- Tingling
- None
- Non-descriptive

How do the following affect your pain? (please check one for each item):

	<i>Pain is Better</i>	<i>Pain is Worse</i>	<i>No Difference</i>
Lying Down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Travel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cough or sneeze	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bowel movement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting/Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weather changes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Turning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Straightening up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Does pain interrupt your sleep? Yes No

TREATMENT FOR PAIN

Using the scale below, indicate the amount of relief obtained for all medications you have tried for this pain.

1= no relief

2= some relief

3= good relief

Please enter a number 1, 2 or 3 in the boxes that apply to you:

Antidepressants

- Paxil
 Elavil
 Celexa
 Effexor
 Other:

Muscle Relaxants

- Flexeril
 Robaxin
 Soma
 Baclofen
 Methocodone
 Norflex
 Parafon Forte
 Cyclobenzaprine
 Skelaxin
 Zanaflex
 Other:

Non-Steroidal

Anti-Inflammatory Drugs

- Aspirin
 Celebrex
 Feldene
 Ibuprofen (Advil)
 Bextra
 Naprosyn
 Voltaren
 Vioxx
 Mobic
 Anaprox
 Aleve
 Other:

Oral Narcotics

- Codeine
 Darvocet
 Dilaudid
 Duragesic Patch
 Methodone
 MS Contin
 OxyContin
 Percocet/Percodan
 Talwin/Talacor
 Tylenol # 3
 Other:

Other

- Acetaminophen
 Ultram
 Fiorinal
 Steroids
 Other:

Anticonvulsants

- Neurontin
 Trileptal
 Tegretol
 Dilantin
 Depakote
 Zonegram
 Keppra
 Other:

For each treatment listed below that you have tried, choose one number indicating the result:

1= no relief

2= some relief

3=good relief

chiropractor exercise physical therapy surgery traction

psychotherapy TENS (Electrical stimulator) injection therapy

provential medications

PREVIOUS DIAGNOSTIC STUDIES

	WHEN	WHERE	ORDERING PHYSICIAN
<input type="checkbox"/> EMG/NCV	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> MRI	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> CAT SCAN	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> MYELOGRAM	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> BONE SCAN	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> ARTHROGRAM	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> PLAIN X-RAY	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> DISKOGRAM	<input type="text"/>	<input type="text"/>	<input type="text"/>

PAST MEDICAL HISTORY

Check if you have had any of these medical conditions before.

Respiratory

- asthma
- COPD/Emphysema

Neurology

- seizures
- stroke (CVA)
- mini stroke (TIA)
- paralysis
- headaches

GI/Hepatic/Pancreatic

- cirrhosis
- pancreatitis
- ulcer
- gastritis
- hepatitis

Cancer

Type:

Renal

- infections
- kidney failure

Endocrine

- diabetes
- thyroid disorder

Rheumatoid/Connective Tissue Disorder

- gout
- arthritis
- scleroderma
- ankylosing spondylitis
- fibromyalgia
- lupus

Cardiovascular

- congestive heart failure
- high blood pressure
- blood clots in the leg
- heart attack

Blood Disorder

- anemia
- HIV/AIDS

PAST SURGICAL HISTORY (please note the date of all that apply):

	<u>Date</u>		<u>Date</u>
<input type="checkbox"/> appendectomy	<input type="text"/>	<input type="checkbox"/> back surgery	<input type="text"/>
<input type="checkbox"/> neck surgery	<input type="text"/>	<input type="checkbox"/> tubal ligation	<input type="text"/>
<input type="checkbox"/> gallbladder	<input type="text"/>	<input type="checkbox"/> tonsillectomy	<input type="text"/>
<input type="checkbox"/> hernia repair	<input type="text"/>	<input type="checkbox"/> coronary artery bypass	<input type="text"/>
<input type="checkbox"/> hysterectomy	<input type="text"/>	<input type="checkbox"/> hemorrhoid	<input type="text"/>
<input type="checkbox"/> C-section	<input type="text"/>	<input type="checkbox"/> prostate	<input type="text"/>
<input type="checkbox"/> kidney	<input type="text"/>	<input type="checkbox"/> bladder	<input type="text"/>
<input type="checkbox"/> brain	<input type="text"/>	<input type="checkbox"/> stomach	<input type="text"/>
<input type="checkbox"/> joint	<input type="text"/>	<input type="checkbox"/> Other	<input type="text"/>

PRESENT MEDICATIONS

List prescriptions *currently* taking:

<u>Name of Drug</u>	<u>How often</u>	<u>Ordering Physician</u>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Do you have any drug allergies to medications?

Do you have any reactions to IVP dye, Latex, strawberries, anesthesia, etc.?

REVIEW OF SYMPTOMS

Have you had any of the following symptoms in the **last 2 weeks**?

General

- unexpected weight loss
- fever

Gastrointestinal/ Abdomen

- nausea/ vomiting
- constipation
- abdominal pain
- blood in stool

Musculoskeletal

- muscle weakness
- swelling of extremities

Endocrine

- appetite change
- cold intolerance

Hematologic/ Hepatic

- jaundice

Cardiopulmonary

- chest pain
- fast heart rate
- cough
- wheezing
- shortness of breath
- require oxygen supplement

Neurological

- headaches
- dizziness

Skin

- rash

Genitourinary

- urinary retention
- blood in urine
- abnormal menstrual cycle

Eyes

- visual disturbance

Ear, Nose, Throat

- ringing in ears
- hearing disturbance
- bleeding gums

FAMILY HISTORY

Does any ***blood relative*** in your family have the following?

	<u>Yes</u>	<u>No</u>
Rheumatoid arthritis	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>
Lupus	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
Fibromyalgia	<input type="radio"/>	<input type="radio"/>
Blood disorder	<input type="radio"/>	<input type="radio"/>

SOCIAL HISTORY

Occupation

If you are working full or part time, when did you return to work?

If not currently working, when was your last day?

Marital Status (choose one): Single Married Separated Divorced Widowed

Present living situation (if living with more than one individual, check primary head of household you are living in):

Alone With spouse With children With parents With friend With other family member

Substance intake per day:

Caffeine (coffee, tea, cola, etc.) #of drinks

Nicotine (cigarettes, cigar, pipe, etc.) Pk/day Yrs

Alcohol:

None Rarely (less than 1 drink per month) Occasionally (less than 1 drink per week)

Regularly (drink 2-3 times/week) Daily Former Abuser

Have you recently used any of the following drugs? (Choose all that apply):

Marijuana Amphetamines Cocaine Heroin None of these

Other: Former Abuser

