PAIN CLINIC PATIENT HISTORY

Date: _____

1. Name: Last _____ First _____ MI _____
2. Address: _____
3. Primary phone (_____)_____ Alternate phone (_____)_____
4. Who referred you? _____
5. Where do you have pain? _____
6. What is your main complaint? _____
7. When did this pain begin? _____
8. What causes your current pain? _____
9. List any other painful conditions you have had in the past. _____
10. What time of day is your pain the worst? _____
11. What time of day is your pain the best? _____
12. What makes your pain better? _____
13. What makes your pain worse? _____

Indicate your level of pain on the following scale	**NO PAIN=0**										**WORST POSSIBLE PAIN=10**
14. Your pain right now	0	1	2	3	4	5	6	7	8	9	10
15. The average intensity of your pain this week:	0	1	2	3	4	5	6	7	8	9	10
16. Your pain at its worst	0	1	2	3	4	5	6	7	8	9	10
17. Your pain at its least	0	1	2	3	4	5	6	7	8	9	10

18. Please list all current medications (prescriptions, over the counter, homeopathic, other):

Name of medication	Strength (mg)	Number per day (24 hour)

19. Please list any medications that you tried in the past and if they helped or not: _____

_____

20. I AM **ALLERGIC** to _____

21. Have you used the following for the current pain problem?

Physical Therapy	Yes___ No___	Injections	Yes___ No___
Heat	Yes___ No___	Surgery	Yes___ No___
Cold	Yes___ No___	Pain Psychology	Yes___ No___
TENS Unit	Yes___ No___	Alternative treatments	Yes___ No___

22. List all Previous Surgeries

	Date

Pain Language: Circle the **ONE** best word in each box that describes your pain. If no words apply, leave box blank.

Flashing/Shooting/Lancinating	Hot/Burning/Scalding/Searing	Dull/Hurting/Aching/Heavy	Cool/Cold/Freezing
Fearful/Frightful/Terrifying	Punishing/Cruel/Killing	Gnawing/Cramping/Crushing	Annoying/Miserable/Unbearable
Throbbing/Pulsing/Pounding	Sharp/Cutting/Lacerating	Spreading/Radiating/Piercing	Agonizing/Dreadful/Torturing

23. Have you had any of the following symptoms since your pain started? (circle yes or no)

Unplanned weight loss	Yes	No	Fevers	Yes	No	Shortness of breath	Yes	No
Flu-like symptoms	Yes	No	Night sweats	Yes	No	Trouble controlling your bowels	Yes	No
Heartburn	Yes	No	Constipation	Yes	No	Trouble controlling your bladder	Yes	No
Persistent diarrhea	Yes	No	Bleed easily	Yes	No	Chest pain or angina	Yes	No
Numbness toes	Yes	No	Bruise easily	Yes	No	Blueness of toes/fingers	Yes	No
Numbness fingers	Yes	No	Skin problems	Yes	No	Skin color changes	Yes	No
Changes in swallowing	Yes	No	Sexual probl	Yes	No	Frequency of urination	Yes	No

24. Do you have any of the following? (circle yes or no)

Heart attack	Yes	No	Heart surgery	Yes	No	High Blood Pressure	Yes	No
Heart Murmur	Yes	No	Palpitations	Yes	No	Heart Valve Problems	Yes	No
Blood Transfusion	Yes	No	HIV	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No	Hepatitis	Yes	No	Heartburn/hiatal hernia	Yes	No
Bleeding ulcers	Yes	No	Kidney stones	Yes	No	Bleeding Abnormality	Yes	No
Asthma	Yes	No	Thyroid	Yes	No	Been treated for depression	Yes	No
Trauma to spine	Yes	No	Diabetes	Yes	No	Been treated by psychiatrist	Yes	No
Seizures	Yes	No	Strokes	Yes	No	Kidney Disease	Yes	No
Lung Disease	Yes	No	Liver Disease	Yes	No	Anemia	Yes	No

25. Do you have any other medical problems not listed above: _____

26. Does anyone in your immediate family have medical problems: (eg) bleeding problems, heart attack, rheumatoid arthritis, chronic pain, lupus, diabetes, cancer _____

_____

27. How much do you smoke? _____ packs per day (for how long) _____ yrs. If quit when _____

28. How much alcohol do you drink? (what) _____ How often _____

29. Have you ever or do you now use any recreational drugs? Yes/ No (What/When) _____

30. Average number of hours you sleep _____. How often do you awake at night from pain _____

31. Anything else that you feel that we should know about you _____

32. On the drawings below please mark the areas where you currently experience pain