INTEGRATIVE PAIN MANAGEMENT S.C.

New Patient Pain History

Name:_____ Date:_____

Primary Care Doctor:_____ Referral Physician:_____

Is this a work-related injury? **Y / N**

When did your pain begin?_____

How did your pain begin?_____

Location of your worst pain_____

Other painful areas_____

Describe your pain:

❒Constant ❒Intermittent ❒Episodic (no pattern) ❒Aching ❒Stabbing ❒Throbbing

❒Pressure ❒Pins & needles ❒Numbness ❒Traveling ❒Burning ❒Shooting

❒Other:_____

Rate your pain: 0 = no pain; 10 = worst pain imaginable

|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse?

_____

_____

What makes your pain better?

_____

_____

Prior Treatment (include all physicians, therapies, chiropractor, injections, and medications to help with your pain)

_____

_____

_____

Diagnostic Tests & Procedures completed:

❒MRI ❒CT ❒X-Ray ❒EMG ❒Lab Tests

❒Bone Scan ❒Other:_____

Allergies (List Reactions e.g. rash, shortness of breath, etc):

_____

_____

Medications and Dosage

Pain Meds:

_____

_____

Other Meds:

_____

_____

_____

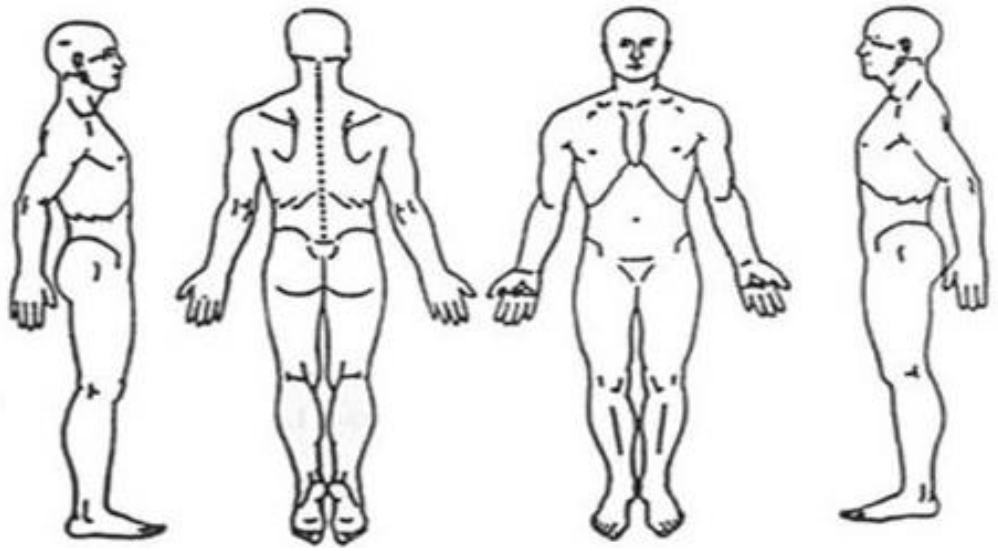
_____

_____

(Please use back for additional meds.)

Please mark your **Worst** pain with an "X"

Draw Your Pain



Are you experiencing any of the following?

❒Unexplained sadness ❒Inability to enjoy activities ❒Flashbacks ❒Physical Violence

❒Sexual Abuse ❒Phobias ❒Loss of appetite ❒Panic attacks

❒Sleeping problems: ❒Falling asleep / ❒During Sleep

How many hours do you sleep?_____

Do you feel depressed (sad, empty)? ❒No ❒Mildly ❒Moderately ❒Significantly

Have you ever been arrested? **Y/N** Have you ever been jailed? **Y/N**

Is there any legal action relating to your pain?_____

Health & Surgical History (Patient)

❒Heart Disease

❒Stomach/Bowel Problems

❒Loss of Bowel/Bladder Function

❒Bleeding Problems

❒TB Exposure/Positive Skin Test

❒Sexually Transmitted Disease(s)

❒History of Balance Problems/Falls

❒Fever/Chills

❒Urinary/Kidney Problems

❒Eye Promblems (Dryness/Itching)

❒Liver Disease: (❒Hepatitis ❒Cirrhosis)

❒Attention Deficit Disorder

❒High Blood Pressure

❒Diabetes

❒Head Injury/Faint/Dizziness

❒Fibromyalgia

❒AIDS/HIV

❒Cancer: (What Type:_____)

❒Lung Disease: (❒Asthma ❒COPD ❒Emphysema)

❒Reflux/Hiatal Hernia

❒Skin/Gum Problems/Dry Mouth

❒Depression/Anxiety: ❒Suicidal Ideation

❒Weight Loss OR ❒Weight Gain

-How Much:____ What Length of Time:_____

❒Neurological: ❒Stroke ❒Seizure

❒Fracture/Sprains/Skeletal:_____

❒Muscle Problems/ Weakness

❒Night Sweats

❒Other Medical Problems:_____

_____

_____

Surgeries (List extras on back of this sheet) :_____

_____

_____

_____

Family History: F = Father M = Mother S = Sibling

___Chronic Pain ___Fibromyalgia ___Arthritis ___Bleeding Disorder

___Substance Abuse ___Alcohol Abuse ___Diabetes ___Hypertension (High Blood Pressure)

___Heart Disease ___Migraine ___Depression ___Suicide

___Cancer; *type:*_____

Social/Vocational History:

❒Married/Lives with Spouse ❒Never Married ❒Divorced/Separated ❒Widow/*er*

❒Lives with Significant Other ❒Lives Alone

List your Hobbies:_____

_____

Who do you seek for Social Support:_____

_____

Employment:

Current Employer:_____ Occupation:_____

Last Day Worked:_____ Retired:_____

Job Satisfaction: ❒Good ❒Fair ❒Poor

Is Return To Work Possible?: ❒Yes ❒No

Does your work involve:

Standing: ❒Yes ❒No If yes, how long at a time?_____

Driving: ❒Yes ❒No If yes, how long at a time?_____

Walking: ❒Yes ❒No If yes, how long at a time?_____

Lifting: ❒Yes ❒No If yes, how many lbs.?____ 6-8 Lifts/hour: ❒More Than ❒Less Than

Sitting: ❒Yes ❒No If yes, how many hours per day?_____

Habits:

❒Caffeine(*amount per day)*_____

❒Smoking(*amount per day)*_____

❒Alcohol(*amount per day)*_____

❒Have you ever used any illicit drugs? If checked, what kind?_____

Certification

To be signed by the Patient

I certify that I have answered truthfully all the questions and I have not knowingly withheld any information concerning any of the above problems, either past or present.

_____

Patient Name (Print)

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

_____ _____

Reviewing Physician Signature Date

Stop Here. The following section will be used by the Physician ONLY.

Physician Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____