PAIN MANAGEMENT

PATIENT HEALTH HISTORY

Patient sticker

(05/16)

YOUR INFORMATION	Height: ________ Weight: ________ BMI: ________
Full Name: ❑M ❑F	**Occupation:** **Employment:** ❑FT ❑PT ❑Retired ❑Student ❑Disabled
Living Status: ❑Lives Alone ❑With Spouse ❑Skilled Nursing ❑Other: specify:	
Primary Care Physician:	**Who Referred You?:** Dr:_______________ ❑Other:
Worker's Compensation Case: ❑Y ❑N	**Are there any pending lawsuits regarding your pain?** ❑Y ❑N

YOUR ALLERGIES	PAST PAIN MANAGEMENT
❑**NO ALLERGIES** Indicate ALL allergies you have to medication and/or food & describe reaction: ______ ______ ______	❑**NONE** ❑**Epidurals** ______ ❑**Trigger Point Injections**______ ❑**Nerve Blocks**______ ❑**Ablation**______ ❑**Narcotic Management**______

RADIOLOGY STUDIES

Study	Date	Where was this done?
XRAYS:		
MRI:		
EMG/Nerve Conduction Study:		
CAT Scan:		
Myelogram:		
Bone Scan:		

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS

Please indicate any CURRENT problems including personal and/or IMMEDIATE FAMILY medical history

Heart/Circulation:	Self	Family	(staff comments)
High blood pressure	❑	❑	______
Heart attack	❑	❑	______
Heart disease	❑	❑	______
Heart failure	❑	❑	______
Chest pain	❑	❑	______
Irregular heart beat	❑	❑	______
Pacemaker	❑	❑	______
Blood Clots	❑	❑	______
Aneurysm	❑	❑	______
Other:	❑	❑	______
Neurological:			
Stroke/mini stroke	❑	❑	______
Weakness/paralysis	❑	❑	______
Numbness	❑	❑	______
Epilepsy/seizures	❑	❑	______
Memory loss	❑	❑	______
Chronic headaches	❑	❑	______
Fibromyalgia	❑	❑	______
Dizziness	❑	❑	______
Depression/anxiety	❑	❑	______
Ear/Nose/Throat:	❑	❑	
Hearing loss	❑	❑	______
Cataracts	❑	❑	______
Glaucoma	❑	❑	______
Sinus problems	❑	❑	______
Other:			

Respiratory:	Self	Family	(staff comments)
Asthma	❑	❑	______
COPD	❑	❑	______
Emphysema	❑	❑	______
Tuberculosis	❑	❑	______
Short of breath	❑	❑	______
Home oxygen	❑	❑	______
Sleep apnea	❑	❑	______
Endocrine:			
Diabetes	❑	❑	______
Thyroid disorder	❑	❑	______
Cancer/tumor	❑	❑	______
Other:	❑	❑	______
G.I./G.U.			
Liver disease	❑	❑	______
Kidney/bladder	❑	❑	______
Reflux/ulcers	❑	❑	______
Intestine problems	❑	❑	______
Females Only:			**LMP:**______
Other:	❑	❑	______
Hepatitis	❑	❑	______
HIV	❑	❑	______
Skin infections	❑	❑	______
Osteoporosis	❑	❑	______
Arthritis/Gout	❑	❑	______
Recent infection	❑		______

YOUR SURGICAL HISTORY

❑No Surgeries   **Please list any surgeries (including childhood) and approximate dates:**

____
____
____
____

YOUR SOCIAL HISTORY

Tobacco Use: ❑Never ❑Current ❑**Former** Type:_______________Years Used:_____ Packs/day:__________________________	**Alcohol Use:** ❑Yes ❑No ❑Former Frequency:__________________________ Type: (circle) Beer Wine Liquor **Street/Recreational Drug Use:** ❑**Y** ❑**N**	**Caffeine Use:** ❑Yes ❑No Type:______________________________ Daily Amount:_______________________

YOUR PAIN HISTORY

What is the reason for your visit today?

When did this condition start (onset)?

Have you received physical therapy for this condition? ❑**Y** ❑**N**   **If yes, when?**

What is the frequency of your pain? ❑**Constant** ❑**Often Present** ❑**Occasional/Intermittent** ❑**Rare**

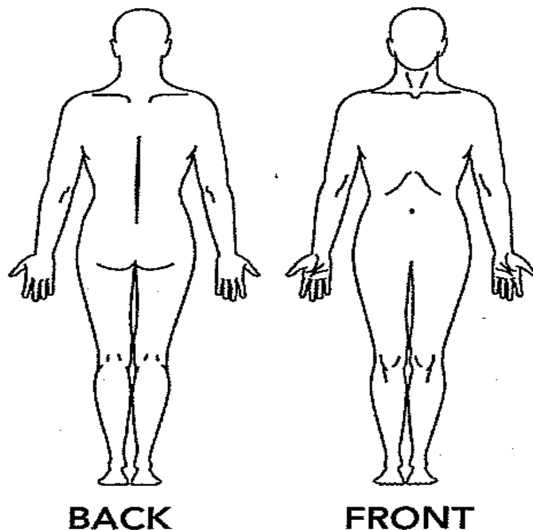
What causes your pain to INCREASE? ❑**Sitting** ❑**Standing** ❑**Walking** ❑**Bending** ❑**Twisting** ❑**Lifting** ❑**Climbing stairs** ❑**Exercise** ❑**Lying Down** ❑**Other:**_________________________________

What causes your pain to DECREASE? ❑**Rest** ❑**Sitting** ❑**Standing** ❑**Lying Down** ❑**Bending Forward** ❑**Stretching** ❑**Walking** ❑**Ice** ❑**Heat** ❑**Medication** ❑**Brace/splint** ❑**Other:**_________________________________

How would you describe your pain? *(check all that apply)* ❑**Aching** ❑**Burning** ❑**Sharp** ❑**Dull** ❑**Deep** ❑**Throbbing** ❑**Electrical** ❑**Shooting** ❑**Sensitive** ❑**Cold/Hot** ❑**Numbness/Tingling**

Does your pain travel anywhere? ❑ **Y** ❑**N**   **Where?**

On the diagram, indicate the areas where you feel pain.



On a scale of 0 (no pain) to 10 (worst you can imagine): (circle number)

Usual level: 0 1 2 3 4 5 6 7 8 9 10

Highest level: 0 1 2 3 4 5 6 7 8 9 10

Lowest level: 0 1 2 3 4 5 6 7 8 9 10

Does your pain interfere with your sleep? ❑**Y** ❑**N**
Does your pain affect your mood? ❑**Y** ❑**N**

What can we do today to make your visit here more comfortable?_______________________________
____

Do you have a Living Will/Advanced Dircective? ❑**Y** ❑**N**

To the best of my knowledge, the information I have provided is complete and accurate for the use of my treatment plan.

Patient Signature:____________________**Date:**__________

Reviewed by:_________________________________Date:_______________

Reviewed by:_________________________________Date:_______________

Patient Sticker