COMPREHENSIVE PAIN SPECIALISTS

NAME: _____ **AGE:** _____ **DATE:** _____

REFERRING DOCTOR: _____

ARE YOU: ☐ MALE ☐ FEMALE
☐ RIGHT HANDED ☐ LEFT HANDED ☐ AMBIDEXTROUS

WORK HISTORY:

OCCUPATION: _____ EMPLOYER: _____ HOW LONG IN POSITION? _____

PLEASE DESCRIBE YOUR JOB DUTIES: _____

_____

ARE YOU WORKING? ☐ NO DATE LAST WORKED: _____
☐ YES ☐ FULL TIME ☐ PART TIME

RESTRICTIONS: ☐ NO ☐ YES

IF YES, PLEASE DESCRIBE: _____

_____

_____

CHIEF COMPLAINT:

REASON FOR VISIT: _____

LOCATION OF YOUR PAIN:

☐ HEAD	☐ SHOULDER	☐ MID BACK	☐ LEG
☐ NECK	☐ ARM	☐ LOW BACK	☐ KNEE
☐ HEADACHES	☐ WRIST/HAND	☐ HIPS/BUTTOCKS	☐ ANKLE/FOOT

HISTORY OF PRESENT ILLNESS:

DATE OF INJURY OR SYMPTOM ONSET: _____

TYPE OF INJURY: ☐ SPORTS INJURY ☐ JOB ACCIDENT ☐ CAR ACCIDENT

☐ OTHER (EXPLAIN): _____

PLEASE DESCRIBE IN DETAIL HOW YOU INJURED YOURSELF: _____

_____

_____

_____

PLEASE DESCRIBE YOUR **CURRENT SYMPTOMS:** _____

_____

_____

Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable
Intermittent	Continuous	

Circle the number that best describes your pain at its **worst during the last month**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

Circle the number that best describes your pain at its **least during the last month**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

Circle the number that best describes your pain **on average during the last month**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

Circle the number that best describes your pain as it is **right now**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

WHAT MAKES YOUR PAIN WORSE? _____

WHAT MAKES YOUR PAIN BETTER? _____

SINCE ONSET, IS YOUR PAIN: ☐ BETTER ☐ SAME ☐ WORSE

IF YOUR PAIN HAS CHANGED, BY WHAT PERCENTAGE: 10 20 30 40 50 60 70 80 90 100%

PREVIOUS TREATMENT:

HAVE YOU HAD TREATMENT SINCE YOUR INJURY? ☐ NO ☐ YES

E.R.?	☐ NO ☐ YES	WHERE? _____	DATE _____		
X-RAYS?	☐ NO ☐ YES	WHERE? _____	BODY PART _____	DATE _____	
CT SCAN?	☐ NO ☐ YES	WHERE? _____	BODY PART _____	DATE _____	
MRI?	☐ NO ☐ YES	WHERE? _____	BODY PART _____	DATE _____	
EMG?	☐ NO ☐ YES				
EPIDURAL?	☐ NO ☐ YES				

OTHER (PLEASE EXPLAIN) _____

MEDICAL:

DR. _____ DATE OF 1ST VISIT _____ LAST VISIT _____

DIAGNOSIS GIVEN: _____

MEDICATIONS GIVEN: _____

OTHER TREATMENT PROVIDED: _____

DR. _____ DATE OF 1ST VISIT _____ LAST VISIT _____

DIAGNOSIS GIVEN: _____

MEDICATIONS GIVEN: _____

OTHER TREATMENT PROVIDED: _____

DR. _____ DATE OF 1ST VISIT _____ LAST VISIT _____

DIAGNOSIS GIVEN: _____

MEDICATIONS GIVEN: _____

OTHER TREATMENT PROVIDED: _____

CHIROPRACTIC: ☐ NO ☐ YES

DR. _____ DATE OF 1ST VISIT _____ LAST VISIT _____

DIAGNOSIS GIVEN: _____

FREQUENCY: ☐ EVERY DAY ☐ THREE TIMES/WEEK ☐ TWO TIMES/WEEK ☐ WEEKLY

HAS IT HELPED? ☐ NO ☐ YES

PHYISCAL THERAPY: ☐ NO ☐ YES

DATE OF 1ST VISIT _____ LAST VISIT _____ ONGOING? ☐ NO ☐ YES

HAS IT HELPED? ☐ NO ☐ YES HOME EXERCISE PROGRAM? ☐ NO ☐ YES

TREATMENT RECEIVED IN THERAPY:

☐ HOT/COLD PACKS ☐ TRACTION ☐ RANGE OF MOTION ☐ EXERCISE/STRENGTHENING
☐ ULTRASOUND ☐ MASSAGE ☐ AEROBICS ☐ AQUA THERAPY (POOL)

FUNCTIONAL HISTORY:

HAS THIS CONDITION INTERFERED WITH YOUR:

SOCIAL LIFE? ☐ NO ☐ YES
SEXUAL FUNCTION? ☐ NO ☐ YES
HOBBIES/SPORTS? ☐ NO ☐ YES
WORK? ☐ NO ☐ YES

AT ANY ONE TIME HOW MANY HOURS CAN YOU: SIT: _____ STAND: _____ WALK: _____

IN AN 8 HOUR DAY, HOW MANY HOURS CAN YOU: SIT: _____ STAND: _____ WALK: _____

HOW MANY POUNDS CAN YOU LIFT AT ONE TIME? _____

HOW OFTEN? ☐ NEVER ☐ OCCASIONALLY ☐ FREQUENTLY ☐ CONTINUOUSLY

HOW FAR CAN YOU WALK? ☐ 0-2 BLOCKS ☐ 4-6 BLOCKS ☐ A MILE OR MORE

CAN YOU USE YOUR HANDS FOR:

	RIGHT		LEFT	
SIMPLE GRASPING	☐ NO	☐ YES	☐ NO	☐ YES
PUSHING /PULLING CONTROLS	☐ NO	☐ YES	☐ NO	☐ YES
FINE MANIPULATION	☐ NO	☐ YES	☐ NO	☐ YES

CAN YOU USE YOUR FEET FOR REPETITIVE MOVEMENTS IN PUSHING AND PULLING CONTROLS?

RIGHT: ☐ NO ☐ YES LEFT: ☐ NO ☐ YES BOTH: ☐ NO ☐ YES

ARE YOU ABLE TO:

	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
BEND	☐	☐	☐	☐
SQUAT	☐	☐	☐	☐
CROUCH	☐	☐	☐	☐
CLIMB	☐	☐	☐	☐
REACH OVERHEAD	☐	☐	☐	☐
GET ON KNESS	☐	☐	☐	☐

Circle the numbers below that best describe how your condition has interfered with your daily functioning.

General Activity

0 1 2 3 4 5 6 7 8 9 10

Mood

Does not interfere — Completely interferes

0 1 2 3 4 5 6 7 8 9 10

Walking Ability

Does not interfere — Completely interferes

0 1 2 3 4 5 6 7 8 9 10

Normal Work Routine

Does not interfere — Completely interferes

0 1 2 3 4 5 6 7 8 9 10

Relations With Other People

Does not interfere — Completely interferes

0 1 2 3 4 5 6 7 8 9 10

Sleep

Does not interfere — Completely interferes

0 1 2 3 4 5 6 7 8 9 10

Enjoyment of Life

Does not interfere — Completely interferes

0 1 2 3 4 5 6 7 8 9 10

Ability to Concentrate

Does not interfere — Completely interferes

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Appetite

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

What level of pain do you think you could function with on a daily basis?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain imaginable

CURRENT MEDICATIONS FROM DOCTORS AND DENTISTS:

1_____ MG ___ DOSAGE_____ 2_____ MG ____ DOSAGE_____

3_____ MG ___ DOSAGE_____ 4_____ MG ____ DOSAGE_____

5_____ MG ___ DOSAGE_____ 6_____ MG ____ DOSAGE_____

7_____ MG ___ DOSAGE_____ 8_____ MG ____ DOSAGE_____

MEDICATION ALLERGIES: ☐ NO ☐ YES

IF YES, PLEASE LIST:

1. _____ / REACTION: _____

2. _____ / REACTION: _____

3. _____ / REACTION: _____

PAST MEDICAL HISTORY:

☐ ANXIETY	☐ HEART ATTACK/CAD	☐ POLIO	☐ THYROID TROUBLE
☐ DEPRESSION	☐ HIGH BLOOD PRESSURE	☐ CLAUSTROPHOBIA	☐ MIGRAINES
☐ ASTHMA	☐ LIVER DISEASE/HEPATITIS	☐ ULCERS/PUD	☐ HIGH CHOLESTEROL
☐ CANCER	☐ LUNG DISEASE	☐ RHEUMATIC FEVER	☐ ALCOHOLISM
☐ ARTHRITIS	☐ STROKE	☐ DIABETES	☐ SEXUALLY TRANSMITTED DISEASE
☐ HEART MURMUR			

HAVE YOU HAD SIMILAR SYMPTOMS/INJURY BEFORE? ☐ NO ☐ YES

IF YES, WHEN: _____ PLEASE DESCRIBE BRIEFLY: _____

_____

PAST SURGICAL HISTORY:

HAVE YOU HAD ANY SURGERIES? ☐ NO ☐ YES

IF YES, PLEASE LIST TYPE OF SURGERY/DIAGNOSIS AND DATE:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

FAMILY HISTORY:

PLEASE CHECK BOX FOR ANY MEDICAL CONDITION THAT A BLOOD RELATIVE HAS A HISTORY OF:

☐ ANXIETY	☐ ARTHRITIS	☐ PSYCHIATRIC ILLNESS	☐ ULCERS
☐ DIABETES	☐ DEPRESSION	☐ HIGH CHOLESTROL	☐ ALCHOLISM
☐ HEART ATTACK	☐ STROKE	☐ ASTHMA	☐ HIGH BLOOD PRESSURE
☐ CHRONIC PAIN	☐ THYROID DISEASE	☐ CANCER	☐ MIGRAINES
☐ DISABILITY	☐ LUNG DISEASE		

NUMBER OF BROTHERS: _____ NUMBER OF SISTERS: _____

FATHER: ☐ ALIVE / ☐ DECEASED: AGE _____ CAUSE: _____

MOTHER: ☐ ALIVE / ☐ DECEASED: AGE _____ CAUSE: _____

SOCIAL HISTORY:

MARITAL STATUS: (CHECK ONE OR MORE)

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ "LIVING TOGETHER" ☐ SEPERATED

NUMBER OF CHILDREN: _____ AGE(S): _____

DO YOU SMOKE? ☐ NO ☐ YES HOW MUCH? _____

PREVIOUS SMOKER? ☐ NO ☐ YES WHEN STOPPED? _____

DO YOU DRINK ALCOHOL? ☐ NO ☐ YES HOW MUCH? _____

COFFEE, TEA, COLA BEVERAGES (CUPS/GLASSES/CANS PER DAY) _____

DO YOU USE RECREATIONAL DRUGS? ☐ NO ☐ YES

IF YES, WHAT TYPE/HOW OFTEN? _____

REVIEW OF SYSTEMS: PLEASE CHECK IF YOU **CURRENTLY** EXPERIENCE ANY OF THE FOLLOWING.

GENERAL
☐ FEVER ☐ WEIGHT GAIN/LOSS ☐ FATIGUE ☐ NIGHT SWEATS
☐ CHILLS ☐ WEAKNESS

DERMATOLOGIC
☐ JAUNDICE ☐ ITCHING/RASH ☐ LESIONS ☐ EASY BRUISING

HEAD
☐ TRAUMA ☐ HEADACHES ☐ TENDERNESS ☐ DIZZINESS

HEARING
☐ CHANGES (LOSS) ☐ RINGING IN EARS ☐ DISCHARGE

VISION
☐ CHANGES (LOSS) ☐ BLURRED VISION ☐ DISCHARGE ☐ GLASSES
☐ BLINDNESS ☐ RINGS AROUND LIGHTS ☐ DOUBLE VISION ☐ LIGHT SENSITIVITY

PULMONARY
☐ WHEEZING ☐ SHORTNESS OF BREATH ☐ CHRONIC COUGH ☐ COUGHING UP BLOOD

CARDIOVASCULAR
☐ CHEST PAIN ☐ SHORTNESS OF BREATH WITH EXCERTION ☐ LEG SWELLING
☐ RACING HEART ☐ USE >2-3 PILLOWS AT NIGHT

GASTROINTESTINAL
☐ NAUSEA ☐ ABDOMINAL PAIN ☐ DIFFICULTY CONTROLLING BOWELS ☐ BLOODY STOOLS
☐ VOIMITING ☐ HEARTBURN ☐ CHANGE IN COLOR OF STOOL ☐ CONSTIPATION
☐ DIARRHEA

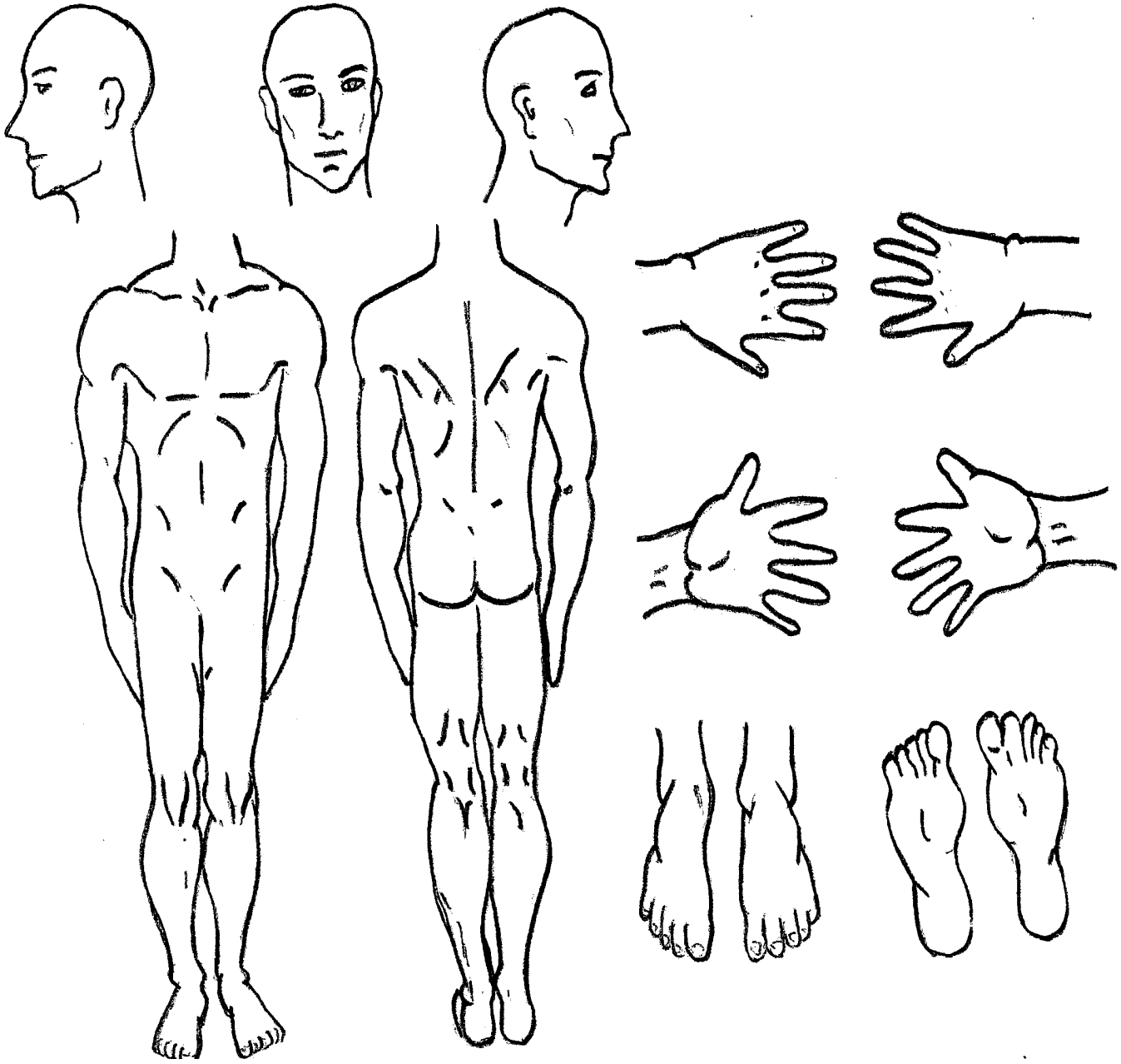
GENITOURINARY
☐ PAIN/BURN ON URINATION ☐ URGENCY WITH URINATION ☐ FREQUENCY OF URINATION ☐ INCONTINENCE
☐ BLOOD IN URINE ☐ URINATION AT NIGHT ☐ STERILITY/IMPOTENCE ☐ DISCHARGE
☐ VENEREAL DISEASE ☐ PREGNANT ☐ SEXUAL PROBLEMS ☐ MENOPAUSE
☐ PAINFUL MENSTRUATION ☐ IRREGULAR MENSTRUATION ☐ VAGINAL BLEEDING

MUSCULOSKELETAL

☐ ARTHRITIS ☐ JOINT SWELLING ☐ TRAUMA

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOL. MARK AREAS OF RADIATION. INCLUDE ALL AFFECTED AREAS.

NUMBNESS OOOO ACHE ^^^^^ STABING //// TINGLING ==== CRAMPING ☐☐☐☐ BURNING XXXX



FOR STAFF USE ONLY – PLEASE DO NOT COMPLETE

HEIGHT _____ **WEIGHT** _____ **BLOOD PRESSURE** _____/_____ **GRIP STRENGTH: L.** ____ ____ ____

R. ____ _____ ____

CIRCUMFERENCE: UPPER ARM: L. _____ **FOREARM: L.** _____ **THIGH: L.** _____ **CALF: L.** _____

R. _____ **R.** _____ **R.** _____ **R.** _____