COMPREHENSIVE PAIN SPECIALISTS

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

REFERRING DOCTOR: _____

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

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 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	

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 _____	

OTHER? _____

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: _____

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)

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: _____

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