INTERDISCIPLINARY PAIN HISTORY

Please take a moment to complete this form. This intake form will allow us to serve you better. Please answer all questions if possible.

DATE OF VISIT: ________________ MR#: ______________________

(PLEASE PRINT)

Name: (Last) (First) (M.I.)

Date of Birth: Age:

Who Referred you? Name: ________________________________

Address: ________________________________

Phone:

Other physicians seen for your condition(s):

Specialty: Name:

I. Chief Complaint:

II. History of Present Illness:

Where is your pain?

Approximate date of onset of the present problem?

How did the problem occur?

Timing of pain/problem? (When do symptoms occur? Example: after meals, exercise, etc.)

Duration of pain/problem? (How long have you had symptoms?)

What measures relieve the pain?

What makes the pain worse?

How many times do you awaken at night?

How many hours a night do you sleep? Consecutive Hours:

Do you have difficulty falling asleep? Yes No

Does your pain make you anxious or irritable?

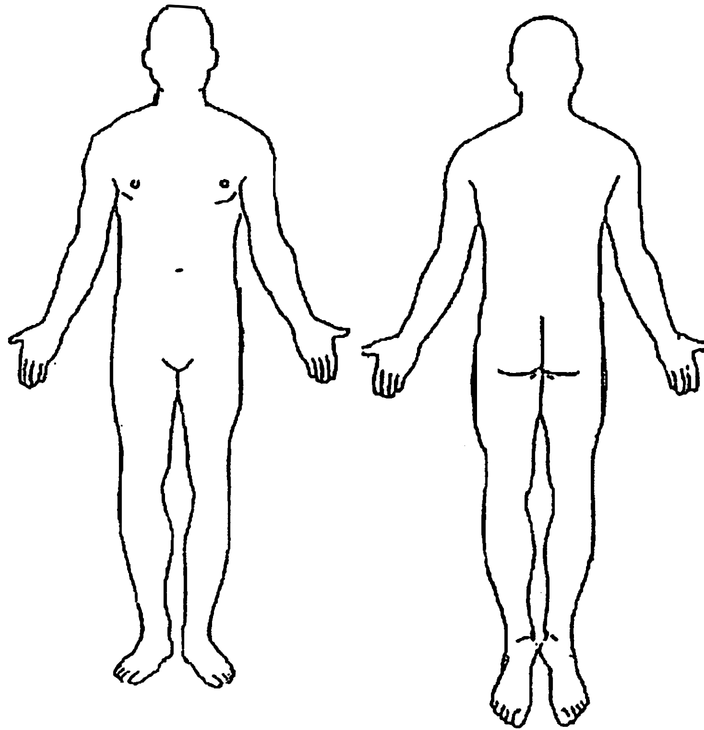
What was your sleep pattern before your pain?

NAME: MR# DATE:

Intensity of pain (circle number on Pain Diagram below)
On Pain Diagram mark the drawings according to where you hurt, indicating which sensations you feel to the key below:

KEY	
//////	Stabbing
XXXX	Burning
0000	Pins & Needles
€€€€	Numbness
+++++	Aching
PAIN LEVEL	
0	No Pain
1	Mild pain you are aware of but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain, you begin to feel antisocial
5	Severe Pain
7-9	Intensely severe pain
10	Most severe pain

☐ RIGHT HANDED
☐ LEFT HANDED



FRONT BACK

CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

NAME: MR# DATE:

III. PAST MEDICAL HISTORY:	Circle Yes or No	IV. Treatment History:
		What treatments have you tried to eliminate your pain?
Diabetes:	Yes No	TENS: No Yes
Hypertension	Yes No	Physical Therapy No Yes - How Many Treatments? _______
Cancer	Yes No	
Stroke	Yes No	____
Heart Trouble	Yes No	Injections No Yes
Arthritis/gout	Yes No	
Convulsions	Yes No	What type of injections? ________________________________
Bleeding tendency	Yes No	
Acute infections	Yes No	________________________________
Venereal disease	Yes No	
Hereditary defects	Yes No	What facility administered these treatments? __________________
Depression	Yes No	____
Anxiety	Yes No	Effective Not Effective
Thyroid	Yes No	What did they do? Heat Cold Ultrasound Massage Exercise
Any Other Medical Conditions:		Electrical Stimulation Other: ____________________
____________		____
____________		Acupuncture No Yes
____________		Pool Therapy No Yes
		Chiropractors:
		____
		Massage:
		____
		____

IV. PAST SURGICAL HISTORY:

YEAR	Hospital/Location	REASON

NAME: MR#: DATE:

V. ALLERGIES:

To Medications	Known Food Allergies

VI. CURRENT MEDICATION (S):

(Please include prescription drugs, and drugs you buy over the counter)

Medications you are taking for pain:	Dose/Strength	When do you take it?	Does the medication help? (Circle yes or no)
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
Other Medications:			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Medication tried which did not work:	Dose:	Result:
Neurontin		
Lyrica		
Tegretol		
Dilantin		
Depakote		
Trazadone		
Elavil		
Restoril		
Wellbutrin		
Prozac		
Zoloft		
Paxil		
Effexor		
Cymbalta		
		(Continued next page...)

NAME: MR# DATE:

Medication you tried which did not work:	Dose:	Result:
MS Contin		
Oxycontin		
Duragesic		
Methadone		
Dilaudid		
Norco		
Vicodin		
Tylenol #3		
Naprosyn		
Celebrex		
Voltaren		
Relafen		
Motrin		
Advil		
Other:		

VII. FAMILY HISTORY: (circle any that apply)

Cancer Kidney Disease Diabetes Liver Disease Stroke

Heart Disease High BP Lung Problems Migraine

Depression Anxiety Thyroid Fibromyalgia

Other____

VIII. SOCIAL HISTORY (circle answer):

Marital Status: Single Married Separated Divorced Widowed

# of Children: ____________________

Use of Alcohol: Never Rarely Moderate

Use of Tobacco: Never Previously, but quit Current packs/day ____________

Use of "Street Drugs" Never Type/Frequency ______________________

Excessive Exposure at home or work to: Fumes Dust Solvents Noise Airborne particles

Occupation: ______________________

Highest Level of Education: (Years) ____________

Lives In: House Condo/Townhouse Apartment Lives with: ________________

Number of Stairs_________ Elevator ____Yes ____No

NAME: MR# DATE:

IX. FUNCTIONAL HISTORY:

(Check activities that are limited because of pain)

__ Feeding	__ Meal Preparation	__ Walking one block	__Stair climbing
__ Dressing	__Housekeeping	__Bicycling	__Driving
__ Bathing	__Outdoor Activities	__Jogging	__Playing sports
__ Toileting	__Shopping	__Exercising	__Other____________
__ Laundry	__Gardening		____________

X. EXERCISE HISTORY:

1. Are you a member of a health club?
2. What type of exercise equipment do you have at home? (List them)
3. Do you have a self-exercise program?
4. How often do you exercise?
Motivation:
What is your motivation to participate in therapy? (0 being Low - 10 being High)
What would you like to achieve as a result of this visit? 1. 2. 3.

XI. MENTAL HEALTH:

1. Do you have any emotional or mental health conditions?
2. Have you ever been hospitalized for these conditions?
3. What treatments are you receiving?
4. If you are being treated, who is treating you ?

NAME: MR# DATE:

XII. REVIEW OF SYSTEMS: (circle yes or no)

Constitutional Symptoms:
(Circle Yes or No)

Recent weight change	Yes	No
Fever	Yes	No
Fatigue	Yes	No
Headaches	Yes	No

Eyes:

Eye disease or injury	Yes	No
Blurred or double vision	Yes	No
Glaucoma	Yes	No

Ears/Nose/Mouth/Throat

Hearing loss or ringing	Yes	No
Chronic sinus problem	Yes	No
Sore throat or voice change	Yes	No
Swollen glands in neck	Yes	No

Cardiovascular:

Heart trouble	Yes	No
Chest pain	Yes	No
Palpitations	Yes	No
Shortness of breath	Yes	No
Swelling of feet, ankles, hands	Yes	No

Musculoskeletal:

Joint pain	Yes	No
Joint stiffness/swelling	Yes	No
Weak in joints/muscle	Yes	No
Muscle pain/cramps	Yes	No
Back Pain	Yes	No
Cold extremities	Yes	No
Difficulty in walking	Yes	No

Respiratory:

Chronic or frequent coughs	Yes	No
Spitting up blood	Yes	No
Asthma or wheezing	Yes	No

Gastrointestinal:

Loss of appetite	Yes	No
Change in bowel movements	Yes	No
Frequent diarrhea	Yes	No
Painful bowel/constipation	Yes	No
Blood in stool	Yes	No
Abdominal pain	Yes	No
Heartburn	Yes	No
Peptic ulcer	Yes	No

Genitourinary:

Frequent urination	Yes	No
Burning or painful urination	Yes	No
Blood in urine	Yes	No
Incontinence	Yes	No
Kidney stones	Yes	No
Sexual difficulty	Yes	No
Male - testicle pain	Yes	No
Female - Painful period	Yes	No
# of pregnancies	______	
# miscarriages	______	

NAME: MR# DATE:

REVIEW OF SYSTEMS (continued):

Integumentary: (Circle Yes or No)			Psychiatric:		
Rash or Itching	Yes	No	Memory loss or confusion	Yes	No
Change in hair or nails	Yes	No	Nervousness	Yes	No
Breast Pain	Yes	No	Depression	Yes	No
Breast Lump	Yes	No	Insomnia	Yes	No
Neurological:			**Endocrine:**		
Light headed or dizzy	Yes	No	Thyroid Disease	Yes	No
Convulsions or seizures	Yes	No			
Numbness or tingling sensations	Yes	No	Excessive thirst or urination	Yes	No
Tremors	Yes	No	Heat or cold intolerance	Yes	No
Paralysis	Yes	No	Skin becoming dryer	Yes	No
Stroke	Yes	No			
Head Injury	Yes	No			
Allergic/Immunologic:			**Hematologic/Lymphatic:**		
History of skin/adverse reaction	Yes	No	Bleeding or bruising tendency	Yes	No
Penicillin or other antibiotics	Yes	No	Anemia	Yes	No
Morphine/Demerol/other narcotic	Yes	No	Past transfusion	Yes	No
Novocaine or other anesthetics	Yes	No	Enlarged glands	Yes	No
Aspirin or other pain remedies	Yes	No			
Tetanus antitoxin or other serum	Yes	No			
Iodine, methiolate, antiseptic	Yes	No			

Patient ____ Date ____ Physician ____ Date ____

Legal Issues:

Do you have any pending lawsuits? Yes ☐ No ☐

Are you on Disability? Yes ☐ No ☐

Are you applying for Disability Yes ☐ No ☐

Have you been denied Disability Yes ☐ No ☐

Is your pain problem related to work? Yes ☐ No ☐

How many work related injuries have you had? (circle number): 0 1 2 3 4 5 _____other