PainCare
manage pain • improve life

www.PainMD.com
Health History Form

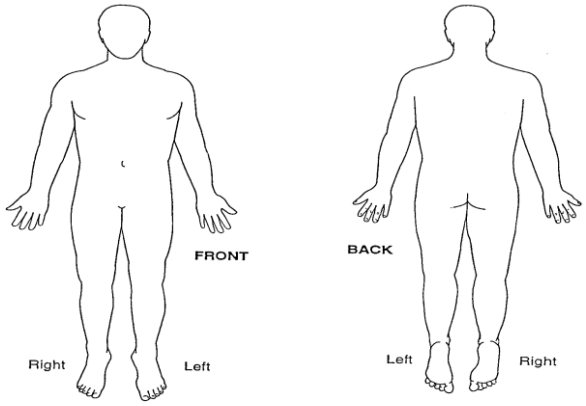
Name: _____ **Date of Birth:**_____/_____/_____

Reason for today's visit: __

PAIN TREATMENT HISTORY

PAIN:	**Location 1**	**Location 2**	**Location 3**
Where is your pain?			
When did it start?			
How did it begin? *(Suddenly, gradually, injury, at work, fall, etc.)*			
What does it feel like? *(Burning, aching, sharp, dull, shooting, etc.)*			

Please draw on the diagram where your pain is located.



(Circle one)

Pain level now? (0=no pain, 10= worst imaginable pain)	0	1	2	3	4	5	6	7	8	9	10
Average pain level over the last month	0	1	2	3	4	5	6	7	8	9	10
Lowest that it has been in the last month or two	0	1	2	3	4	5	6	7	8	9	10
Highest that it has been in the last month or two	0	1	2	3	4	5	6	7	8	9	10

(Please circle <u>all</u> that apply)

What aggravates your pain? heat | cold | activity | driving | lying down | sitting | standing | walking bending | lifting | weather | prolonged positions | stress

What relieves your pain? heat | cold | activity | rest | lying down | sitting | standing | walking massage | changing positions | stretching | medication

Associated signs & symptoms: problems sleeping | depression | anxiety | sexual issues decreased range of motion | difficulty urinating | saddle anesthesia | bowel or bladder dysfunction | numbness or tingling

Pain is worse in: morning | afternoon | evening | night

Pain is: continuous | intermittent

Please list any diagnostic tests, x-rays, etc. you have had.

TEST	X-RAY	CT SCAN	MRI SCAN	EMG	OTHER
WHEN					
WHERE					

List medications *TRIED* for pain and their effectiveness:

Medication:	Effect:	Medication:	Effect:

What types of treatments have you tried and were they effective? (Ex. Physical therapy, acupuncture, chiropractor, etc.)

Treatment:	Effective?	Treatment:	Effective?

What other providers have you seen for pain? *(Include other pain clinics, specialists, and primary providers)*

1) **Provider Name**:_____ **Office Name**:_____

   Address: _____ Phone: _____

   Are you still a patient? Yes / No **If yes**, have you been there in the last 2 years? Yes / No

2) **Provider Name:_____ Office Name:_____**

   Address:_____ Phone:_____

   Are you still a patient? Yes / No **If yes,** have you been there in the last 2 years? Yes / No

3) **Provider Name:_____ Office Name:_____**

   Address:_____ Phone:_____

   Are you still a patient? Yes / No **If yes,** have you been there in the last 2 years? Yes / No

4) **Provider Name:_____ Office Name:_____**

   Address: _____ Phone:_____

   Are you still a patient? Yes / No **If yes,** have you been there in the last 2 years? Yes / No

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CURRENT MEDICATIONS

Name of Medication	**Strength** (ex. 500 mg)	**Dosing Instructions** (ex. Twice a day)

ALLERGY HISTORY

☐ No Known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal Allergies ☐ Latex Allergies

Allergen (ex. Food, Dust, Animals, Pollen, Medication)	**Reaction** (ex. Rash, nausea, respiratory, shock, etc.)

SOCIAL HISTORY *(Please circle all applicable responses)*

Marital Status	Single Significant Other Married Divorced Widowed	
Living Situation	Alone Spouse/Significant other Children/Family Other	
Females- Are you pregnant?	Yes / No Hysterectomy Menopause Tubal ligation	
Do you have children?	Yes / No	If yes, how many?
Education (highest level)	9 10 11 12 Some college Associates Bachelors GED Masters PhD	
Are you working?	Yes / No	If yes, occupation?
Are you disabled?	Yes / No	If yes, reason?
Any legal actions related to a pain condition?	Yes / No	Explain:

			If applicable, amount?
Tobacco Use?	Yes / No	Cigarettes / Cigars / Chew	Per day:
If no, have you ever?	Yes / No	Cigarettes / Cigars / Chew	Per day:
Do you drink alcohol?	Yes / No	Beer / Wine / Liquor	Per day:
Do you drink caffeine?	Yes / No	Coffee / Tea / Soda / Energy Drink	Per day:
Any present illicit drug use?	Yes / No	Marijuana / Cocaine / Heroin / Illicit Rx. / Other	
Any past illicit drug use?	Yes / No	Marijuana / Cocaine / Heroin / Illicit Rx. / Other	
Do you exercise?	Yes / No	Type?	Per week:
Do you wear your seatbelt?	Yes / No	If yes, percent of time:	
Do you have Advanced Directives in place?	Yes / No	Living Will Durable Power of Attorney Health Care Proxy Advanced Directives	

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MEDICAL HISTORY *(Please check any of the following that you have or have had in the past)*

☐ Acid Reflux/GERD	☐ Cancer	☐ Headaches	☐ Kidney Disease
☐ ADHD	☐ Chronic Cough	☐ Hearing Loss	☐ Liver Disease
☐ Alcoholism	☐ Chronic Pain	☐ Heart Disease	☐ Osteoporosis
☐ Anemia	☐ COPD/Emphysema	☐ Heart Palpitations	☐ Seizure Disorder
☐ Anxiety	☐ Dementia	☐ Hepatitis	☐ Sexually Transmitted Disease
☐ Arthritis	☐ Depression	☐ High Blood Pressure	☐ Stroke
☐ Asthma	☐ Diabetes	☐ High Cholesterol	☐ Thyroid Disease
☐ Bleeding Disorders	☐ Eating Disorder	☐ HIV/AIDS	☐ Tuberculosis
☐ Bowel Problems	☐ Glaucoma/Cataracts	☐ Immune disorders	☐ Other:_____

FAMILY HISTORY *(Please tell us about the health of your immediate family)*

	Father	Mother	Siblings	Children	Other
Age at Death					
Cause of Death					
Heart Disease/ Stroke					
High Blood Pressure					
Diabetes					
Cancer (type)					
Epilepsy/Seizures					
Asthma					
Blood Disease					
Other:					

SURGICAL HISTORY *(*Please list <u>all</u> past surgeries/operations)**:**

Type of Operation	Date	Type of Operation	Date

MEDICAL AND MENTAL HEALTH HISTORY (Include <u>all</u> injuries or hospitalizations)**:**

Name of Facility	Reason	Date