PAIN TREATMENT CENTER

PATIENT HISTORY

Last Name, First Name, Middle Name or Initial ______ Age ______ Occupation ______

Referring Doctor ______ Date Questions Answered ______ Time ______

The following questions are important in helping the nurses, doctors and other healthcare providers at Pain Treatment Center make decisions about the care you might need. Please answer all the questions that you can. The nurse will be glad to help you answer any question that you do not understand or any that you're having difficulty with the answer. Before you see the doctor a Registered Nurse will review your answers and ask you for additional information that she may need.

PAIN ASSESSMENT | **OFFICE USE ONLY - COMMENTS**

1. Have you ever been a patient of a Pain Clinic or Center? ❑ Yes ❑ No
   If yes, where: ______
2. What type of pain or health problem are you here to see the physician about today? ______
3. When did you first notice symptoms of your pain problem?
   Date: ______ Day of Week: ______ Time of day ______
4. Were you emotionally, mentally and physically well before your pain began? ❑ Yes ❑ No
5. What type of activity were you doing when the pain began? ______
6. Where were you when the pain began? ______
7. Where was your pain located when it began? ______
8. Where is your pain located now? ______
9. Check the one that best describes your pain: ❑ sharp ❑ aching ❑ throbbing ❑ shooting
   Other: ______
10. Does your pain move from one area to another? ❑ Yes ❑ No
    (If yes) Where does your pain move? ______
    (If yes) If yes, how long was it before your pain moved? ❑ Minutes ❑ Hours ❑ Days
11. What causes your pain to start or get worse? ______
12. What causes your pain to stop or get better? ______
13. Does your pain stop your sleep? ❑ Yes ❑ No
    If yes, ❑ one time each night ❑ two times each night ❑ many times each night
14. Check the box if you have any of the following and describe the location where it occurs:
    ❑ Abnormal or decreased feeling to touch or temperature If so, where? ______
    ❑ Unable to move your arm, leg, or other part of your body If so, where? ______
    ❑ Loss of coordination If so, where? ______
    ❑ Change in skin color If so, where? ______
    ❑ Change in skin temperature ❑ Hot ❑ Cold Where? ______
15. Below are drawings that will help you describe where your pain is located. Please color or shade in the areas on the drawings that best describe where your pain is now.

Left Right Left Right Right Left Left Right R L L R Left Right R L L R

16. Below is a line to help you show what the level of your pain is. 0 describes "no pain" and 10 represents the "worst pain" you ever had. Circle the number on the line that best describes your pain between the levels of "no pain and "worst pain".

No Pain | 0 1 2 3 4 5 6 7 8 9 10 | Worst Possible Pain

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PAIN ASSESSMENT (cont.)

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17. Check the one that best describes how often you have your pain:
 ❑ Always present, always the same level ❑ Always present, but level changes
 ❑ Occasional with pain-free periods ❑ Rarely present with only few days or weeks

ACTIVITY ASSESSMENT

These questions are designed to give the doctor information about how your pain has affected your everyday life. Please answer every section, and mark in each section only the one box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Personal Care (Washing, Dressing, etc.)

❑ I can look after myself normally without causing extra pain.
❑ I can look after myself but it causes extra pain.
❑ It is painful to look after myself and I am slow and careful.
❑ I need some help but manage most of my personal care.
❑ I need help every day in most aspects of self-care.
❑ I do not get dressed, wash with difficulty and stay in bed.

Walking

❑ Pain does nor prevent me walking any distance.
❑ Pain prevents me walking more than one mile.
❑ Pain prevents me walking more than 1/2 mile.
❑ Pain prevents me walking more than 1/4 mile.
❑ I can only walk using a stick or crutches.
❑ I am in bed most of the time and have to crawl to the toilet.

Standing

❑ I can stand as long as I want without extra pain.
❑ I can stand as long as I want but it gives me extra pain.
❑ Pain prevents me from standing more than one hour.
❑ Pain prevents me from standing for more than than 30 minutes.
❑ Pain prevents me from standing for more than then ten minutes.
❑ Pain prevents me from standing at all.

OCCUPATIONAL / FAMILY / SOCIAL HISTORY

1. Are any of your family members receiving disability or other support because of health problems? ❑ Yes ❑ No
2. Has anyone in your family ever had a problem like yours? ❑ Yes ❑ No
3. Describe the type of work that you do: ____________________
 Check all that apply: ❑ heavy lifting ❑ constant strain ❑ standing most of the time ❑ sitting most of the time ❑ frequent bending/turning
4. Has your pain stopped you from working? ❑ Yes ❑ No
 If Yes: ❑ unable to do any work ❑ can work only limited amount
 How long have you been off from work? ____________________
5. Is your pain the result of a work-related injury or accident? ❑ Yes ❑ No
 If Yes: Are you presently receiving financial support? ❑ Yes ❑ No
 Are you planning to sue because of your pain/injury? ❑ Yes ❑ No
 Have you already sued because of your pain? ❑ Yes ❑ No
6. Do you smoke? ❑ Yes ❑ No
 If Yes: ❑ 1/2 pk/day ❑ 1 pk/day ❑ 2 pks/day ❑ more than 2 pks/day
 Do you smoke to relieve pain? ❑ Yes ❑ No
7. Do you use smokeless tobacco? ❑ Yes ❑ No
8. Do you drink alcohol? ❑ Yes ❑ No
 If Yes: ❑ seldom ❑ every day ❑ 1-2 per week ❑ 3 or more times per week
 If Yes: ❑ 1 drink/day ❑ 2-3 drinks/day ❑ more than 3 drinks per day
9. Have you ever used unprescribed drugs? ❑ Yes ❑ No
 If Yes, describe: ____________________

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PAST AND PRESENT MEDICAL HISTORY	OFFCIE USE ONLY - COMMENTS

Marital Status: ❑ Single
❑ Married ________ yrs.
❑ Widowed _______ yrs.
❑ Separated _______ yrs.
❑ Divorced ________ yrs.

Names of Children and/or Dependents	Age

PAST AND PRESENT MEDICAL HISTORY

Check the boxes below if you have ever had or now have any of the medical problems

NOW	PAST		NOW	PAST	
❑	❑	Angina	❑	❑	Stomach Ulcers
❑	❑	Heart Attack	❑	❑	Hiatal Hernia
❑	❑	High Blood Pressure	❑	❑	Liver Disease
❑	❑	Congestive Heart Failure	❑	❑	Hepatitis
❑	❑	Heart Murmur	❑	❑	Kidney Infection
❑	❑	Mitral Valve Prolapse	❑	❑	Bladder Infection
❑	❑	Irregular Heart Beat	❑	❑	Diabetes
❑	❑	Emphysema	❑	❑	Thyroid Problem
❑	❑	Asthma	❑	❑	Arthritis
❑	❑	Bronchitis	❑	❑	Back Stiffness
❑	❑	Frequent Cough	❑	❑	Neck Stiffness
❑	❑	Anemia	❑	❑	Stroke
❑	❑	Blood Clots	❑	❑	HIV/AIDS
❑	❑	Bleeding Disorder	❑	❑	Cancer

List other present medical problems: ____

List other past medical problems: ____

Check the boxes below if you have had any of the following surgeries and write down the date you had it:

	DATE		DATE		DATE
❑ Tonsilectomy	_____	❑ Heart Surgery	_____	❑ Neck Surgery	_____
❑ Appendectomy	_____	❑ Brain Surgery	_____	❑ Knee Surgery	_____
❑ Hernia Repair	_____	❑ Hysterectomy	_____	❑ Hip Surgery	_____
❑ Sinus Surgery	_____	❑ C-Section	_____	Other: ____________	
❑ Stomach Surgery	_____	❑ Tubal	_____		
❑ Gallbladder Surgery	_____	❑ Cystoscopy	_____		
	_____	❑ Back Surgery	_____		

Which of the following types of anesthesia have you had?
❑ General
❑ Spinal/Epidural
❑ Local/IV

Have you ever had any problems with anesthesia or sedation? ❑ Yes ❑ No
If yes, describe: ____

Has anyone in your family ever had problems with anesthesia or sedation? ❑ Yes ❑ No
If yes, describe: ____

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Patient History

OCCUPATIONAL / FAMILY / SOCIAL HISTORY (cont.)	OFFICE USE ONLY - COMMENTS

Write down the names of the medicines you take, the amount that you take and how often you take them.

NAME	AMOUNT/DOSAGE	TIMES EACH DAY

Do you take medications to relieve or reduce your pain?
- ❑ No
- ❑ Yes - less than once a week
- ❑ Yes - many times each week
- ❑ Yes - one or more times
- ❑ Yes - three or four times each day
- ❑ Yes - five or more times each day

How do you take pain medication?
- ❑ Take when needed for pain
- ❑ Take at regular times
- ❑ Take at regular times and when needed

List all medications you have taken in the past that caused an allergic reaction. Describe what happened.

____

____

____

PREVIOUS TESTS / TREATMENTS

If you have had any of the following treatments for your pain, put a check in the box that best describes what it did for you.

TREATMENT	Greatly Helped	Slightly Helped	Did Not Help	Made Pain Worse
Hypnosis	❑	❑	❑	❑
Biofeedback	❑	❑	❑	❑
Tens Unit	❑	❑	❑	❑
Acupuncture	❑	❑	❑	❑
Chiropractor	❑	❑	❑	❑
Physical Therapy	❑	❑	❑	❑
Other ______	❑	❑	❑	❑
______	❑	❑	❑	❑

Have you ever had psychological or psychiatric treatment? ❑ Yes ❑ No

If yes, where: ______________________________

Please list the names of all doctors or chiropractors that you have seen for your pain problems in the past:

____

____

Put a check in the box by all the tests listed below. For each test you've had done, write in the date it was done and where it was done.

TEST	DATE	HOSPITAL or DOCTOR OFFICE
❑ X-Rays ______		
❑ CT Scans ______		
❑ MRI ______		
❑ Nerve Tests ______		
❑ Blood Tests ______		
❑ Bone Scans ______		
OTHER: ______		
______		

PATIENT'S SIGNATURE ______________________________ DATE ______________

R.N. SIGNATURE ______________________________ DATE ______________

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