NEW PATIENT HISTORY FORM
(This form must be completed prior to being seen)

Name: ___________________________________DOB: _________________________ Date:____________________

Referring Physician _______________________________________Primary Physician___________________________

PRIMARY COMPLAINT

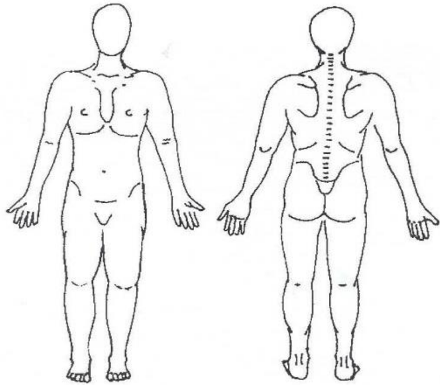
When did your pain start?
____

Under what circumstances did your pain begin? (Please select the appropriate indicator listed below)

_____ At work, but NOT an accident
_____ Following surgery
_____ Following illness
_____ Pain began with no known cause
_____ Accident at work
_____ Motor vehicle accident
_____ Accident at home
_____ Other

Where is the location of your pain?

Please shade the painful areas on the diagram below xxxx for most severe pain ooo for less severe pain * for tingling/burning**



NUMERIC PAIN SCALE

Please circle the number that best describes the amount of pain you feel right now.

No pain *0* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10* *worst pain Imaginable*

What is the highest number that your pain goes to? ______

What is the lowest number that your pain goes to? ______

What best describes your pain? *(Please circle all that apply)*

Burning stabbing shooting aching dull electrical deep vague sharp constant intermittent daily

Other?____

Do you have any numbness? _____Yes _____ No If yes, *where*? ______________________________________

Do you have any weakness? _____ Yes _____ No If yes, *where*?______________________________________

What makes your pain worse? (please circle all that apply)

exercise	bending forward	bending backwards	walking	cold stress
climbing stairs	lifting	sitting	standing	heat
work	driving	cough/sneeze	sexual activity	light touch

other: *(Please describe):*

____

What relieves your pain? (please circle all that apply)

lying down	sitting	standing	walking
physical therapy	exercise	ice	heat
medications	bath/shower	meditation	relaxation

Other *(describe):*

____

Have you ever been treated at another pain management center or program? _____Yes _____ No

If yes, where? ____When?__________________________________

MEDICATIONS

Do you take any blood thinning medication? ________ What?___________________________
(This is not an all-inclusive list but examples of some anticoagulants include Coumadin, Plavix, Aggranox, or others)

List all other pain medications that you have tried in the past and why you stopped:________________________________

____
____
____

List all medications that you are taking <u>now</u>. ***(Include over the counter, herbal, vitamins, and other supplemental medications)***

Medication	Dose (mg)	How often? (# times/day)	What is this medication for?	Date started	Prescribing Doctor

ALLERGIES

Please list any known drug, food, or environmental allergies and indicate the adverse effect/reaction:

____

____

MEDICAL HISTORY

(please check all that apply)

Cardiovascular	Respiratory	Gastrointestinal	Endocrine	Hematologic
___Chest Pain	____Asthma	____Acid Reflux/GERD	____Obesity	____Bleeding disorders
___Heart Attack	____Emphysema	____Ulcers	____Hypothyroid	____Anemia
___Heart Disease	____Chronic Bronchitis	____Polyps	____Hyperthyroid	
___Heart Rhythm Disturbances		____Easy bruising	____Frequent Pneumonia	____Hepatitis A, B, C
___Diabetes	____Anticoagulation	____Arterial Insufficiency	____Positive TB Test	____Pancreatitis
___Insulin	____Venous Insufficiency	____Bowel problems	____Frequent Colds/Sore Throat	
___High Blood Pressure	____Low Blood Pressure	____Blood thinners	____Blood clots	____Abnormal Chest x-ray
___Colitis	____Hiatal Hernia	____Embolism	____Gallbladder problems	____Crohn's Disease
___Irritable Bowel Syndrome		____Liver Disease	____Special Diet	____Other

Neurological	Psychological	Genitourinary	Musculoskeletal

____Memory problems	____Nervous Breakdown	____Sexual Dysfunction	____Fibromyalgia
____Seizures	____Depression	____ Sexually Transmitted Disease	____Rheumatoid Arthritis
____Stroke	____Anxiety	____Prostate Disease	____Osteoarthritis
____Movement Disorder	____Panic Disorder	____Kidney Problems	____Osteoporosis
____Muscular Dystrophy	____Psychosis	____Chronic Infection	____Back Problems
____Neuropathy	____Alcohol or drug abuse	____Bladder Problems	____Neck Problems
____Migraine	____ Other		
____Epilepsy			
____Headaches			

Cancer	Miscellaneous	General	Allergic/Immunological
Site __________________	____Glaucoma	____Medical Equipment	____Autoimmune disorder
Diagnosis Date _________	____Cataracts	____Cane	____Lupus, Sjogren's
		____Walker	____Raynaud's Syndrome
Chemotherapy _______	____Visual Problems	____Wheel Chair	____Immune deficiency
Radiation ____________	____Hearing Loss	____Hospital Bed	____HIV
Other ______________	____Chronic Skin Disorder	____Oxygen at ___ LPM	
	____Pregnancy		
	____________Date of last period		

SURGICAL HISTORY

(Please list all surgeries)

DATE	SURGERY	DOCTOR

FAMILY MEDICAL HISTORY

Please check what applies

- ○ Back Problems
- ○ Migraines
- ○ Heart Attack
- ○ Cancer
- ○ Diabetes
- ○ Seizures
- ○ Depression
- ○ Stroke
- ○ Anxiety
- ○ Hypertension

Has family experienced any problems resulting in similar conditions or chronic pain? ____Yes ____No

SOCIAL HISTORY

Smoking habits: _________ packs per day for ______ years

Alcohol intake: ____________________ Amount & Frequency___________________

PSYCHOSOCIAL HISTORY

Highest level of education_____________ Are you going to school now? ______________

Are you able to care for yourself________________ if not, who helps you?__________________________

Have you fallen lately? Y N When? _______ Do you use any assistive device at home? (walker, cane, etc.) ______________

What exercise or recreational activities do you enjoy? ____

How often do you exercise or do the above activities? ____

Do you feel safe in your home? _____Yes_____No If not, why? ____

Have there been any other stressful life experiences recently? ___Yes____No If so, explain: ______________________________

Have you ever had thoughts of suicide or harming yourself ? _____Yes _____No If yes, did you seek help? ____Yes ____No

Have you ever had thoughts of harming someone else? ___Yes ___No If yes, who? _____________________________________

Have you been under the care of a mental health professional? _____ Yes _____No If yes, who? ____

Have you received treatment for alcohol or substance (legal/illegal) abuse? ____Yes______No If yes, when? ____

MEDICAL TESTING

(Select the medical tests below that have been done to evaluate your pain)

	Date (approximate)	Result (if known)
_____ X-ray	_________________	____________________________
_____ CT Scan	_________________	____________________________
_____ Myelogram	_________________	____________________________
_____ MRI	_________________	____________________________
_____ Discogram	_________________	____________________________
_____ Bone Scan	_________________	____________________________
_____ EMG	_________________	____________________________

MISCELLANEOUS

Are you, or have you ever been, involved with any of the following?

Disability:
_______Not receiving or seeking disability
_______Not receiving but seeking or planning to seek disability
_______Receiving disability

Litigation/lawsuit(s):
_______No & not intending pain-related litigation/lawsuit
_______Currently in pain related litigation/lawsuit
_______Past litigation/lawsuit or legal involvements related to pain condition

Motor Vehicle Accidents:
___ Pain not related to motor vehicle accident
___ Pain related to motor vehicle accident and settlement pending
___ Pain related to motor vehicle accident but no settlement pending or necessary

Do you have any other litigation or lawsuits ongoing, pending, planned, or under consideration?

___ Yes ___ No (If so, please explain)
____

REVIEW OF SYSTEMS

(Please circle any of the listed symptoms that are current problems for you)

Constitutional: fever chills weight loss or gain fatigue

Eyes: double vision blurry vision need for glasses injury or surgery

Ear, Nose, Throat: sinusitis hearing loss ringing in ears sores voice change swelling

Cardiovascular: palpitations leg swelling heart attack chest pain high blood pressure

Respiratory: shortness of breath asthma cough spitting up blood wheezing

Gastrointestinal: loss of appetite nausea vomiting blood in stools

Genitourinary: frequent or painful urination incontinence infections irregular menses

Musculoskeletal: Joint pain or stiffness weakness injury or surgery swelling spasm

Skin/Breast: rashes ulcers nail changes breast pain or lump or discharge

Neurological: stroke or TIA headaches dizziness seizures loss of balance

Psychological: memory loss depression insomnia anxiety nervousness

Endocrine: diabetes thyroid problems excessive thirst or urination

Hematologic: bleeding or bruising tendency phlebitis DVT blood clots transfusion

PAIN MANAGEMENT GOALS & EXPECTATIONS

What do you expect from our pain program? (select the ONE best answer)

_____ A diagnosis (to help find the cause of pain)
_____ Help in coping with the pain
_____ A reduction in pain
_____ A cure
_____ No expectations
_____ Do not know what to expect

PAST TREATMENTS

(Please select the treatments you have received for your pain problem, and what was the result?)

Indicate Pain Therapies	Tried	Not Tried	Improved	No change	Worse	Comments
Drug Detoxification						
Epidural steroid injections						
Facet joint injections						
Trigger point injections						
Nerve (lumbar sympathetic, stellate ganglion, etc.) blocks						
Spinal cord stimulation						
Medication pump						
Radiation therapy						
Physical therapy						
Exercise						
Manipulations/Mobilizations						
Traction Exercise/Aerobic conditioning						
Passive (heat, ice, gentle massage, ultrasound)						
Aqua/water/pool therapy						
Trigger point therapy/deep tissue massage/acupressure						
Occupational therapy						
Acupuncture						
Chiropractic						
Prosthetics/Orthotics (e.g. braces, supports, etc)						
Electric stimulation (TENS)						
Biofeedback/relaxation						
Yoga						
Hypnosis						
Other						