

PAIN HISTORY FORM



Referring Physician: _____

Date: _____

Patient Name		Address (City, State, Zip)			Telephone Number ()	
Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Height	Weight
Job Title/Occupation		Employer	Employer's Address		Employer's Telephone ()	
GED/High School Diploma <input type="checkbox"/> Yes <input type="checkbox"/> No		Education – Number of Years Completed		Years of Technical College/Academic College	Degree Received <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a Family Physician <input type="checkbox"/> Yes <input type="checkbox"/> No			Family Physician's Name			

1. Problem you are here for? Explain your symptoms: _____

2. Was this an injury? Yes; No If Yes, date of injury: ___/___/___ If No, date pain began: ___/___/___
 Explain how pain began: _____

3. Where did it start? Work Home Motor Vehicle Accident School Other _____

4. If work-related, was an injury report filed with your employer? Yes No

5. Following the onset of the above, were you seen by a health care professional? Emergency Room Walk-In Clinic Family Doctor Chiropractor Occupational Health Nurse Other _____

6. Were any X-rays, lab or other diagnostic studies obtained? Yes No If Yes, what was done? _____

7. Since this problem started, have you treated with any other providers? Yes No If Yes, who and when?

8. Have you had similar problem(s) or symptoms in the past? Yes No If Yes, when? _____
 Have you previously treated for this problem? Yes No Who did you see? _____
 Did the problem get somewhat better, but is generally present; go away, completely; or, does it come and go periodically. If the pain or symptoms have not completely gone away, or if they still come and go, have you received any further care? Yes No If Yes, when? _____ By who (name of the doctor/chiropractor/other): _____

9. List **all past/present medical problems** (including surgeries, illnesses, broken bones and prior injuries that resulted in medical/chiropractic care, i.e., work-related, motor vehicle accident related, etc.):

Date	Problem/Description	Doctor/Hospital

Patient Name: _____

Date of Birth: _____

Date	Problem/Description	Doctor/Hospital

10. List ALL **Medications**, Vitamins/Herbal remedies you are taking (if additional space is needed, please attach separate sheet to this form):

Name of Medication, Vitamins, etc.	Prescription or Over-the-Counter?	Dosage (Qty.)	How Often (Daily or As-Needed)	Name of Dr. Prescribing Medication

11. **Allergies to Medications?** Yes No; List Allergies: _____

12. **Social History-Habits:**

Do you Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how many packs/day?	Do you Chew Tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of years you have been Chewing/Smoking?	If you quit, how long ago?
Have you ever used Illegal Drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, What and When last used?	Alcohol usage: <input type="checkbox"/> Yes <input type="checkbox"/> No Number of drinks _____ per day/week/month/year (circle one)		Prior Alcohol/Drug Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine (coffee/soda) usage: <input type="checkbox"/> Yes <input type="checkbox"/> No Number of drinks _____ per day/week/month/year (circle one)		Do you exercise on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you exercise on a regular basis prior to the onset of the current problem? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how often? What type of exercise did you do? <input type="checkbox"/> Stretching <input type="checkbox"/> Walking/Running <input type="checkbox"/> Aerobic <input type="checkbox"/> Strengthening/Weights			
Have you <input type="checkbox"/> gained or <input type="checkbox"/> lost weight over the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how many pounds?		Over what period of time did you gain/lose weight? _____ Weeks/Months/Years (circle one)	
Are you currently on a diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type of diet?		Did a Doctor prescribe diet? <input type="checkbox"/> Yes <input type="checkbox"/> No

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13. **Family History:** Have any of your family members had any of the following? (Check Yes or No for each item. If you checked "Yes", please check family member(s) with health condition.)

<u>Health Condition</u>		<u>Family Member</u>		<u>Health Condition</u>		<u>Family Member</u>	
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side	Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side	Lung Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side	Tuberculosis (TB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side
Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side	Degenerative Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side
Stomach Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side	Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side
Bone/Joint Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side	AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side
Muscle Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side	Nervous Breakdown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side
Nerve Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side	Back/Spine Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side
Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side	Emotional Problems or Suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mother's Side	<input type="checkbox"/> Father's Side

14. **Personal Medical History:** (Please circle Y or N. If Yes, check all that apply.)

Y/N **Constitutional:** Chills Fatigue Fever Increased Appetite Loss of Appetite Loss of Appetite
 Night Sweats Weakness Weight Gain Weight Loss Other _____

Y/N **Chronic Infection:** MRSA VRE Hepatitis Other _____

Y/N **Ophthalmology:** Blurred Vision Diminished Vision Double Vision Loss of Vision Drainage from
Eyes Eye Injury Eye Irritation Foreign Object in Eye Sensitivity to Light Pain Flashes of Light
 Legally Blind Macular Degeneration Wears Reading Glasses Wears Glasses Wears Contacts
 Cataracts Glaucoma Other _____

Y/N **Head, Ears, Eyes, Nose, Throat:** Sinusitis Headaches Migraines Glaucoma Hearing Loss Ear
Infections Tonsillitis Abscesses Dental Problems TMJ Dizziness Balance Problems Head
Injury Goiter Masses Cancer Other _____

Y/N **Endocrine Disorders:** History of Thyroid Disease Goiter Hypothyroidism Hyperthyroidism
 Graves Disease Thyroiditis Diabetes Mellitus (insulin dependent/diet controlled/medication by mouth)
 Parathyroidism Pituitary Disorder/Tumor Adrenal Disorder/Tumor

Y/N **Cardiovascular:** Heart Disease High Blood Pressure Stroke MI Coronary Artery Disease
 Bypass Surgery Chest Pain Shortness of Breath Heart Valve Disease Murmur Pacemaker
 Irregular Heart Beat Pounding Heart Racing Heart Fatigue Lower Extremity Swelling
 Blood Clots Other _____

Y/N **Respiratory:** Asthma Bronchitis COPD TB Shortness of Breath Wheezing
 Exposure to Asbestosis/Silicon/Chemicals Sleep Apnea Snoring Lung Cancer
 Other _____

Y/N **Gastrointestinal:** Peptic Ulcers GI Bleeding GERD Gastritis Hiatal Hernia Gall Bladder
Disease Hepatitis Pancreatitis Inflammatory Bowel (Crohn's) Disease Irritable Bowel Disease
 Constipation Diarrhea Blood in Stool Black Tarry Stools Hemorrhoids Bloating Nausea
 Vomiting Food Intolerances Food Allergies Other _____

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Y/N **Female (only):** History of Endometriosis Pelvic Inflammatory Disease Recurring Yeast Infections
 Heavy Menstrual Bleeding Irregular Bleeding Pre-Menopausal Syndrome Hormonal Imbalance
 Fibrocystic Breast Disease Breast Tenderness Nipple Discharge Abnormal Mammogram
 Abnormal Self-Breast Exam Breast Cancer Cancer of Cervix/Uterus/Ovaries Other: _____

Y/N **Male (only):** History of Prostatitis Urethritis Testicular Swelling Pain or Masses Testicular
Cancer Breast Cancer Prostate Cancer Other _____

Y/N **Urology:** Recurring Bladder Infections Irritable Bladder Bladder/Kidney Stones Kidney Infections
 Difficulty Urinating Blood in Urine Cloudy Urine Difficulty Voiding Urinating more than
6x's/day Weak Urine Stream Burning when Urinating Frequent Urination Loss of Control of
Bladder/Dribbling Kidney Disease Other _____

Y/N **Musculoskeletal:** History of Fibromyalgia Osteoarthritis Rheumatoid Arthritis Polymyositis
 Lupus Polymyalgia Rheumatica Recurring Low Back Pain Spinal Disorder Poliomyelitis
 Scoliosis Muscular Dystrophy Dystonia Tendonitis Rotator Cuff Tear Carpal tunnel
Syndrome Lumbar Strain/Sprain Cervical Strain/Sprain Prior Injury/Fracture Total Joint
Replacement/Surgery Joint Pain – Shoulders/Elbows/Wrists/Hands/Hips/Knees/Ankles or Feet

Y/N **Neurological:** History of Head Injury Stroke Seizures Convulsions Epilepsy TIA
 Hardening of the Blood Vessels Aneurysm Arnold-Chiari Syndrome Brain Tumor Brain Cancer
 Loss of Consciousness Blackouts Fainting Spells Dizziness Loss of Vision Double Vision
 Increased Sensitivity to Light Loss of Memory MS Vertigo Loss of Balance Numbness
 Tingling Weakness of a Body Part Paralysis Headaches Migraines Neuropathy (Alcoholic/
Diabetic/Renal/Infectious) Exposure to Lead/Mercury/Arsenic Other: _____

Y/N **Skin/Dermatology:** Rashes Psoriasis Eczema Poor Healing Wounds Vascular Ulcers
Pilonidal Cyst Skin Cancer Other _____

Y/N **Hematological:** History of Bleeding Disorder Anemia Leukemia Lymphoma Polycythemia
 Thrombocytopenia Hodgkin's Disease Blood Disorder AIDS Other _____

Y/N **Allergies/Allergy Symptoms:** Medications (listed earlier) Latex Tape Metals Topical Iodine Injected
Dye Feathers Animals Ear Congestion Environmental Foods _____ Itchy Eyes
 Runny Nose Scratchy Throat Seasonal Sinus Congestion Bee Stings Spider Bites Shellfish Malignant
Hyperthermia (Personal or Family History) Other: _____

Y/N **Psychiatric/Mental Health:** History of Depression Anxiety Phobia's (fears) Reactive Depression
 Bipolar Depression Major Depression Psychosis Nervous Breakdown Post-Traumatic Stress
Disorder Substance Abuse (drugs or alcohol) Physical/Sexual/Emotional Abuse Suicidal Attempts
 Admission for Detox Mental Health Care and/or receiving Medications Psychiatric Hospitalizations or
Counseling Other: _____

15. **Sleep History:** (Check and answer all that apply)

- Do you have difficulty sleeping secondary to pain? Yes No
 - If Yes, did you have difficulty sleeping **prior to onset** of your pain problem? Yes No
- Previously, how long did you sleep? _____ hours/night
- How many hours of rest do you get now? _____ hours/night
- Do you have difficulty falling asleep? Yes No

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- Do you frequently wake up during the night/sleep interrupted? Yes No
- Do you wake up early? Yes No Do you sleep during the day? Yes No
- Do you snore? Yes No
- Have others observed that at times you seem to stop breathing? Yes No
- Upon awakening do you feel Rested or Tired?

16. **Permanent Impairment:**

- Do you believe that you have a permanent condition? Yes No
- Do you believe that you are disabled? Yes No
- What do you feel are acceptable goals if the pain could be relieved?

(Circle the % that best describes your goal.)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No Reduction in Pain Level Complete elimination of pain

- Return to at LEAST _____ % of previously level of activity.
- Return to work? Yes No
- Return to previous job, same employer? Yes No; or,
 new job, same type of work; or, new job, less physical.
- Return to prior recreational activity? Yes No If Yes, what activity? _____

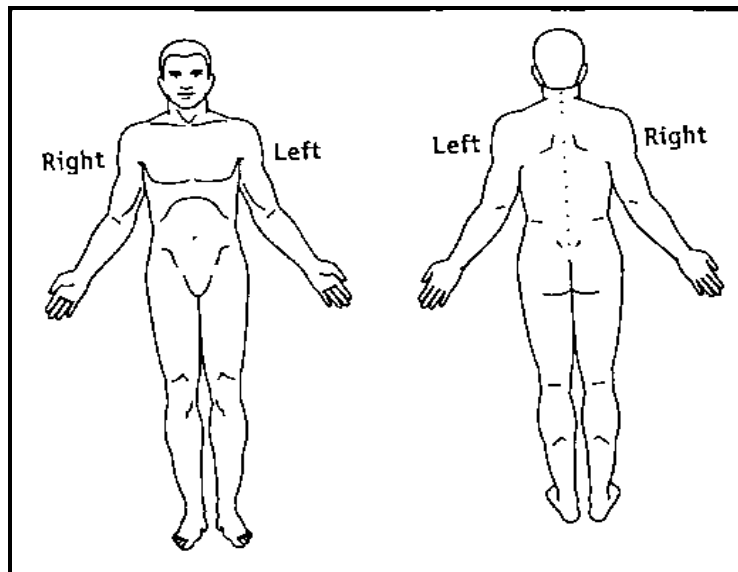
17. Answer the following questions **ONLY** if your injury was **Work-Related**, resulted from a **Motor Vehicle Accident**, or **Personal Injury**:

- Do you have any pending litigation? Yes No Do you expect any compensation? Yes No
 - If Yes, type of compensation: Medical Expenses Property Damage Bodily Injury

BRIEF PAIN INVENTORY

Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains and toothaches).

1. Have you had pain other than these everyday kinds of pain TODAY? Yes No
2. On the diagram below, please shade in the areas where you feel pain. Put an "X" on the area that hurts the MOST.



Patient Name: _____

Date of Birth: _____

3. Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

4. Please rate your pain by circling the number that describes your pain at its LEAST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

5. Please rate your pain by circling the one number that describes your pain on an AVERAGE day.

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

7. Please circle a number that you would consider to be an ACCEPTABLE level of pain.

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

8. What treatments or medications are you receiving for your pain? _____

9. In the past 24 hours, how much RELIEF have pain treatments or medication provided? (Circle %)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No relief Complete relief

10. Circle the one number that describes how, during the last 24 hours, the pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

C. Walking Ability

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

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<u>Task or Activity</u>			
Lift up to 50 lbs.	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Lift up to 75 lbs.	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Lift up to 100 lbs.	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Sit for a period of time	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Kneel on knees	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Squat (deep knee bend)	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Climb stairs	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Bend at the waist below knees	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Twist trunk	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Reach above shoulders	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Repetitively use arms/hands	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Forcefully grip with hands	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Frequently turn head and neck	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Hold head in one position	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Stand for period of time	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful
Walk for period of time	<input type="checkbox"/> I can do	<input type="checkbox"/> I can do with difficulty	<input type="checkbox"/> I am unable to do-too painful

Talking about your pain

It is important to remember that each person's pain is different. The pain that you experience can't be compared to another person's pain. ONLY YOU know how and when you hurt, and how the pain affects your life. It is important to describe what you are feeling to those who are trained to help you. Don't be embarrassed to talk to your physician or nurse. They need to know as much as possible about your pain in order to develop the best plan to control it. The questions on this form can help you describe your pain.

Proper treatment for pain is not only a matter of comfort, but unrelieved pain can lead to nausea, loss of sleep, depression, loss of appetite, weakness and other problems. Pain can affect your life at home and at work. Relieving your pain can mean that you will be able to continue to do the day-to-day things that are important to you.

Comments: Write down any questions or information that you need to share with your physician about your pain.
