

PAIN MANAGEMENT HISTORY AND PHYSICAL FORM

Name: _____ Birth Date: _____ Age: _____ Date: _____

Referring MD: _____ Primary MD: _____

Height _____ Weight _____ Gender _____ Marital Status S ___ M ___ W ___ D ___ Number of Children _____

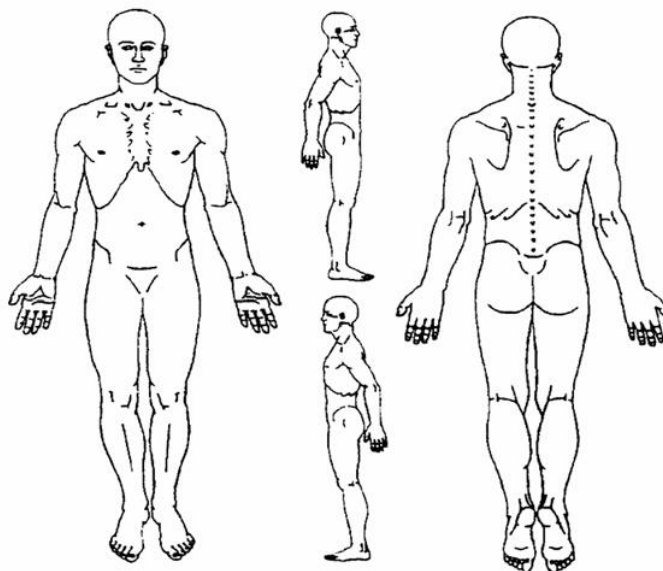
Chief Complaint (Reason for your visit): _____

PAIN HISTORY:

TYPE OF PAIN YOU ARE CURRENTLY EXPERIENCING

Place appropriate symbol or letter on the diagram.

- Ache = AAAA
- Burning = XXXX
- Cramps = CCCC
- Dull = OOOO
- Numbness = NNNN
- Sharp = SSSS
- Shooting = <<<<
- Stabbing = ////
- Throbbing = - - - -
- Tingling = + + + +
- Other Sensation = # # # #
 (Describe it: _____)



PAIN SEVERITY SCALES:

- Please circle the number that best describes your pain **right now**.
 No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain
- Please circle the number that best describes your **typical or usual** pain.
 No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain
- Please circle the number that best describes your pain level **at its best**.
 No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain
- Please circle the number that best describes your pain level **at its worst**.
 No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

HOW DID YOUR PROBLEM START (CHECK ONE)?

- No injury (onset was: Gradual or Sudden)
 Why do you think it started? Date _____
- Injury (from Accident or Sport NOT Work or Auto)
 Date _____, Where and how did it happen?
 What sport _____
- Injury at work (Date _____)
 From a lift twist bend pull reach
- Auto accident (Date _____) How was car hit?

EXPLANATION

HOW OFTEN IS YOUR PAIN PRESENT?

- Rare (several times per month) Occasional (several times per week) Sporadic (several times per day)
- Frequent (several times per hour) Constant

WHAT MAKES YOUR PAIN WORSE?

- Driving Sitting Coughing Sneezing Straining to have a bowel movement Lifting Exercise Twisting
- Lying in bed Bending Squatting Kneeling Climbing stairs Standing Walking Other _____

WHAT MAKES IT BETTER?

- Rest Heat Ice Other _____

HAS YOUR ABILITY TO PERFORM DUTIES AT WORK BEEN AFFECTED?

- No Somewhat Seriously Unable to perform duties

HAS YOUR ABILITY TO PERFORM ANY OF THE FOLLOWING ACTIVITIES BEEN AFFECTED?

- Bathing Grooming Using toilet Getting dressed Walking Preparing meals Climbing stairs
- Household chores Shopping

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING SYMPTOMS?

- Inability to hold your urine (incontinence) Inability to control stool/feces (incontinence) Fever/chills
- Abdominal pain Pelvic pain Weight loss Weakness Other _____

PAIN TREATMENT HISTORY:

PLEASE LIST ANY PREVIOUS DOCTORS WHO HAVE TREATED YOU FOR THIS CONDITION.

HAVE YOU HAD SURGERY FOR THIS CONDITION IN THE PAST? Yes No If yes, please list below:

Surgery Performed	Surgeon	Date
Surgery Performed	Surgeon	Date
Surgery Performed	Surgeon	Date

WHAT OTHER TREATMENTS HAVE YOU TRIED FOR THIS CONDITION?

- Physical therapy: Date begun _____ For how long? _____ Did you improve? _____
- Chiropractic: Date begun _____ For how long? _____ Did you improve? _____
- Steroid injections: Date _____ Type of injection _____ Did you improve? _____
- Accupuncture: Date _____ Did you improve? _____

GENERAL MEDICAL HISTORY:

SURGERIES/DATES (not related to current condition):

MEDICATIONS (or attach list): _____

OVER THE COUNTER DRUGS (or attach list): _____

HERBAL MEDICINES OR VITAMINS: _____

MEDICATION ALLERGIES: _____

Have you ever had a reaction to the dye used in certain radiologic & cardiac x-rays? (i.e. CT Scan dye)

YES NO

SOCIAL HISTORY:

	NO	YES	How long/much
Do you drink alcoholic beverages?	_____	_____	_____
Do you currently smoke?	_____	_____	_____
Have you ever smoked?	_____	_____	_____
Do you or have you used illicit drugs?	_____	_____	_____
Do you exercise?	_____	_____	

If yes what is your routine: _____

Occupation: _____

Describe your job tasks: _____

Are you currently working? Yes No
 Full time Part time Unable to work
 Unemployed Retired On disability

How many days have you missed in the past year due to your pain? _____

FAMILY HISTORY:

Family Member(s)	Alive	Deceased	Current Age or Age at Death	Cause of Death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Do you have FAMILY history of:

	NO	YES	WHO
1. Heart Disease	_____	_____	_____
2. High Blood Pressure	_____	_____	_____
3. Diabetes	_____	_____	_____
4. Stroke	_____	_____	_____
5. Cancer (location)	_____	_____	_____
6. Thyroid Disease	_____	_____	_____
7. Abdominal Aortic Aneurysm	_____	_____	_____
8. Peripheral Vascular Disease	_____	_____	_____
9. Other Disease	_____	_____	_____

PAST HEALTH HISTORY/ROS:

Do you have now or have you ever had any of the following:

	NO	YES	Please Explain
Heart Disease	_____	_____	_____
Heart Attack	_____	_____	_____
High Blood Pressure	_____	_____	_____
Stroke	_____	_____	_____
Chest Pain/Pressure	_____	_____	_____
Heart Failure	_____	_____	_____
Rapid Heart Beat or Irregular Pulse	_____	_____	_____
Swollen Ankles	_____	_____	_____
Pain in calf muscles when walking	_____	_____	_____
Aneurysm	_____	_____	_____
Varicose Veins	_____	_____	_____
Light Headedness	_____	_____	_____
Dizziness	_____	_____	_____
Migraine headaches	_____	_____	_____

	NO	YES	Please Explain
Fatigue	_____	_____	_____
Seizure	_____	_____	_____
Depression	_____	_____	_____
Menstrual dysfunction	_____	_____	_____
Sexually transmitted disease	_____	_____	_____
Anxiety	_____	_____	_____
Arthritis	_____	_____	_____
Blood Disease or Anemia	_____	_____	_____
Autoimmune Disease	_____	_____	_____
Allergies/Hay fever	_____	_____	_____
Cough	_____	_____	_____
Shortness of Breath	_____	_____	_____
Asthma or Emphysema	_____	_____	_____
Cancer (location)	_____	_____	_____
Scarlet Fever	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Thyroid Disease	_____	_____	_____
Hepatitis (Jaundice or Liver Disease)	_____	_____	_____
Kidney Stone(s)	_____	_____	_____
Blood in Urine	_____	_____	_____
Urinary Problem	_____	_____	_____
Ulcer	_____	_____	_____
Colitis	_____	_____	_____
Rectal Bleeding	_____	_____	_____
Stomach or bowel disorder	_____	_____	_____
Change in Bowel Habits	_____	_____	_____
Black Tarry Stool	_____	_____	_____

	NO	YES	Please Explain
Constipation	_____	_____	_____
Gout	_____	_____	_____
Nervous Disorder	_____	_____	_____
Other _____			

PHYSICIAN SIGNATURE: _____

DATE: _____

FOR PHYSICIAN USE ONLY:

HPI: _____

PHYSICAL EXAMINATION:

GEN: well developed/well nourished no acute distress

NEURO: normal speech

RESP: good respiratory effort no wheezing

MSK:

Posture: normal stooped list left/right

Gait: normal guarded limp left/right

Palpation for tenderness: _____

Flexion: _____

Extension: _____

Left lateral bend: _____

Right lateral bend: _____

Twist right: _____

Twist left: _____

SLR tests: _____

ASSESSMENT:

PLAN:

PHYSICIAN SIGNATURE _____

DATE: _____