Westbrook Medical Center, PLLC

Pain Patient History Form

Date_____

Patient Name_____ Age_____

What is your pain problem? (Examples, ruptured disc, arthritis, headaches, neck pain, etc.) _____
_____
_____
_____

How long have you been experiencing this pain? _____

How bad is your pain? (Circle the best choice in each row)

USUAL Pain	No Pain	0	1	2	3	4	5	6	7	8	9	10	Severe Pain
WORSE Pain	No Pain	0	1	2	3	4	5	6	7	8	9	10	Severe Pain
On a Good Day	No Pain	0	1	2	3	4	5	6	7	8	9	10	Severe Pain
Quality of Life	Bad	0	1	2	3	4	5	6	7	8	9	10	Good

Your pain is: (Check all that apply)

( )electric ( )stabbing ( )excruciating ( )constant ( )dreadful
( )throbbing ( )burning ( )intermittent ( )distracting ( )horrible
( )aching ( )crushing ( )discouraging ( )intolerable ( )boring
( )agonizing ( )disabling ( )incapacitating

What makes your pain WORSE? (Check all that apply)

( )nothing ( )bending ( )medications ( )driving ( )walking
( )lifting ( )cold or ice ( )heat/warm bath ( )weather ( )sitting
( )working ( )getting upset ( )standing ( )exercise ( )sex
( )lying down( )physical therapy Other_____

What decreases your pain? (Check all that apply)

( )nothing ( )bending ( )medications ( )driving ( )walking
( )lifting ( )cold or ice ( )weather change ( )sitting ( )working
( )standing ( )exercise ( )heat/warm bath ( )lying down
( )physical therapy Other_____

When do you have pain?
( )all of the time ( )most of the time ( )some of the time ( )occasionally

How many bad days do you have each week? _____

Is your pain changing? ( )staying the same ( )getting worse
( )worse because of new injury ( ) getting better

What tests have been done to study your pain?
( )X-rays ( )MRI ( )CT ( ) Myelogram ( )EMG
Other _____

Have you undergone any of the following treatment options for your pain?
( )physical therapy ( )regional blocks ( )counseling
( )TENS unit ( )chiropractic ( )acupuncture
( )epidurals ( )surgery Other_____

Explain where and when the above tests/treatments were received:
_____
_____
_____
_____
_____

What surgeries have you had?
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____

What medicines have you ever used to control pain? (All medications – prescription, non-prescription and alternative medicines)
_____
_____
_____
_____
_____

What medicines do you use NOW for pain or for any other reason? (All medicines – prescription, non-prescription, and alternative medicines)

_____
_____
_____
_____
_____
_____

What medicines are you allergic to or can not take for other reasons?

_____
_____

Name ALL the doctors, Hospitals, or places that have treated you for your pain.

_____
_____
_____
_____

Name all the pharmacies you have used in the last year with their addresses.

_____
_____
_____
_____

Have you ever had:

( )arthritis ( )high blood pressure ( )mental illness ( ) diabetes
( )cancer ( )spinal disc problems ( )other chronic pain ( )depression
( )alcoholism ( )methadone treatment ( )panic attacks ( )weight problems
( )seizures ( )drug abuse problems ( )sleep problems ( )heart disease
( )strokes ( )other_____

Do any of your blood relatives have: ?

( )arthritis ( )high blood pressure ( )mental illness ( ) diabetes
( )cancer ( )spinal disc problems ( )other chronic pain ( )depression
( )alcoholism ( )methadone treatment ( )panic attacks ( )weight problems
( )seizures ( )drug abuse problems ( )sleep problems ( )heart disease
( )strokes ( )other_____

Symptoms or problems you now have or have had in the last two years:

( )loss of appetite ( )shortness of breath ( )swallowing problems
( )dizziness ( )swelling of ankles ( )numbness of hand
( )nausea, vomiting ( )numbness ( )bleeding problems
( )migraines ( )double vision ( )blurred vision
( )diarrhea ( )tingling ( )headaches
( )incontinence ( )weakness of arm ( )weakness of leg
( )constipation ( )convulsions ( )hearing problems
( )abdominal pain ( )sinus problems ( )depression
( )loss of sex drive ( )bloating ( )palpitations
( )hay fever ( )easy bruising ( )rashes
( )fevers ( )cold intolerance ( )stiffness
( )swollen joints ( )fullness ( )hoarseness
( )runny nose ( )swollen glands ( )chronic cough
( )chest pain ( )numbness of arm ( )numbness of leg
( )poor coordination ( )black-outs, fainting ( )speech difficulties
( )stomach ulcers ( )bloody/black stools ( )bloody urine
( )dry mouth ( )frequent infections ( )asthma
( )lots of fatigue ( )cramps ( )chills
( )heat intolerance ( )heart burn ( )menstrual problems
( )skin sores ( )burning eyes ( )dry skin
( )frequent falls ( )anxiety attacks ( )abnormal discharges
( )weight change ( )pain on urinating ( )tremor or shaking
( )impotence ( )intense fear ( )racing or irregular heartbeat
( )weakness ( )burning on urination ( )difficulty with bladder control
( )itching ( )abnormal sweating ( )difficulty with bowel control
( )muscles cramps ( )congested nose ( )difficulty with taste or smell
( )leg pain ( )arm pain ( )frequent urinating at night
( )I have difficulty getting to sleep ( )I have difficulty staying asleep
( )I wake up tired ( )I'm told I stop breathing in my sleep
( )I have never had an alcohol problem ( )I drink alcohol socially
( )I snore ( )I'm sleepy and tired during the day
( )I stopped smoking in year____ ( )I smoke cigars
( )I have smoked _____years ( )I chew or dip snuff
( )Sometimes I wish I was dead ( )I have tried to kill myself
( )I have had DUIs or DWIs ( ) I sometimes drink in the morning
( )I have had guilty feelings about my drinking
( )I can get annoyed by criticism of my drinking

Personal History: (Check all that apply)

( )right hand predominant ( )left hand predominant ( )married
( )live with spouse and children ( )divorced ( )widowed
( )live with parents ( ) single parent ( )live alone
( )single ( )student, full-time ( )student, part-time
( )separated ( )employed full time ( )employed part time
( )Partially disable ( )Totally disabled ( )I believe in God
( )I am a spiritual person ( )Church life is important ( )College Degree
( )I go to church regularly ( )I cannot read or write
( )High school degree/GED ( )Grade school education
( )Hobbies _____
( )My pain interferes with my personal relations
( )My living conditions are unpleasant or lonely
( )My living conditions are congenial and pleasant
( )I have been in the military
Other_____

If you were temporarily disabled, when were you removed from work and when did you return to work? _____
_____

If you are totally disabled, when were you removed from work and why?
_____
_____
_____

What type work do you do now or what type work have you done in the past?
_____
_____
_____

How many hours are you able to work per week? _____

How many hours do you work per week? _____