

Interventional Pain Care, LLC

Initial Patient History Form

What are you seeing us for?

Who referred you to the Pain Clinic?

When did this pain begin?

Is it associated with an accident? Yes No If so, Date _____. Please describe the details surrounding the event: _____

If you need additional space to tell us about the accident please continue writing on an additional sheet of paper. If you can type the details on a word processor please bring both a printed and a digital copy.

Describe your pain:

Where do you hurt?

How bad is your pain? If 0 is no pain and 10 is the worst pain you can imagine, circle how bad your pain is now: 1 2 3 4 5 6 7 8 9 10

Please circle the least your pain is in the course of a month 0 1 2 3 4 5 6 7 8 9 10

Please circle the worst your pain is in the course of a month 0 1 2 3 4 5 6 7 8 9 10

Please draw on the pain drawing where you hurt. If the pain travels, draw this on the body.

What words describe your pain? (Circle all that apply.)

Sharp Dull Achy
Shooting Burning Boring

What have other doctors diagnosed this problem as?

1. _____
2. _____
3. _____
4. _____

What tests have you undergone for this problem? Please list where the tests were done.

X-rays _____
EMG _____
MRI _____
Blood tests _____
Psychological testing _____

What treatments have you undergone for this problem?

Medications? Please list them.

Have you had physical therapy for this problem?

TENS or other skin surface electrical treatment?

Chiropractic?

VAX D?

Injections?

Surgery? If so, please describe.

Surgery	Surgeon	Date	Hospital
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Do you have other health issues (hypertension, diabetes, thyroid trouble, etc.)? If so, please list them.

Surgical History:

Surgery	Surgeon	Date	Hospital
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Please list all the medications you are taking presently.

Medicine	strength	how often	who prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What medications have you taken in the past but you are no longer taking? Why did you stop taking it?

What other treatments have you undergone? What for, and did it help?

Do you live with anyone now? Please list.

Are your parents living?

Have your parents had a pain condition? If so, please describe.

Does anyone in your family have a chronic pain condition? Please list their relationship and condition.

Do you have any relatives with a drug or alcohol problem (parents, children, siblings)? Yes No

Do you smoke tobacco? Yes No

Do you consume alcohol? Yes No

Occupation:

What is your occupation?

Who is your employer?

Write your job description.

Review of Systems

Circle all that apply, and fill in the blanks.

General

- Fever
- Chills
- Tired
- Trouble Sleeping Hours slept a night _____
- Dizziness
- Forgetfulness
- Weight Loss How much _____
- Weight Gain How much _____

Neurologic

- Headache
 - What part of your head?
 - How often?
 - How long do they last?
 - What treatments work?
 - What treatments did not work?
- pain in legs
- pain in arms

Respiratory

- Sleep apnea
- Cough
- Coughing up sputum
- Sore throat
- Draining sinuses
- Voice change
- Nasal congestion
- Dry Mouth
- Wheezing
- Short of breath in cold
- Short of breath when walking up a flight of stairs
- Do you smoke tobacco products? If so, how many packs a day? _____

Cardiac

- Chest pain or tightness
- Short of breath when walking a block
- Short of breath when lying down
- Have to sleep with your head up
- Wake up at night short of breath
- Rapid heart beat
- Passed out
- Heart Cath or heart surgery

Vascular

- Pain in legs when walking
- Fingers or toes turn blue or black
- Raynauds disease
- Frostbite
- Blood clots
- Gastrointestinal
 - Weight loss
 - Nausea
 - Stomach pain
 - Vomiting blood
 - Dark coffee-ground like bowel movement
 - Blood from your rectum
 - Constipation How often do you usually have a bowel movement? Every _____ days
 - Diarrhea
 - Incontinence of stool
 - When was your last rectal and colon examination? _____.
 - Do you consume alcoholic beverages?
- Lymphatic
 - Swollen glands
- Muscles and Joints
 - Swollen joints: Which ones? _____
 - Painful knots in muscles
 - Feel stiff in the morning
- Urinary
 - Trouble urinating
 - Awaken nightly to urinate: How many times a night? _____
 - History of incontinence
 - Leak urine when you cough or strain
 - Trouble with bladder control (i.e. incontinence)
 - Bladder examination
 - Bladder testing
 - Pain when urinating
 - Blood in urine
 - Pain from flank into scrotum or labia
- Reproductive, male:
 - Unable to have an erection
 - Unable to ejaculate
- Reproductive, female:
 - Last menstrual period _____
 - Could you be pregnant? Yes No
 - Pain around your reproductive organs
- Skin
 - Rash
 - Sores that are not healing
 - Bruise easily
 - Tears easily
- Immune
 - Frequent infections Where? _____
 - Exposed to HIV