PAIN HISTORY

Name: _____ DOB: _____

Referring Physician: _____ PCP: _____

Where is your primary pain located: _____

Date of injury/onset of pain: _____

_____

Briefly describe the history of the problem: _____

_____

_____

(use an additional sheet and attach if needed)

What is the quality (description) of the pain?

☐ aching ☐ throbbing ☐ shock-like ☐ sharp ☐ pins & needles ☐ burning
☐ crushing ☐ pressure ☐ stabbing ☐ other: _____

On a severity scale of 0-10 (0 being no pain and 10 being intolerable) **my pain is** _____ **/ 10 on average**

Is there referred (radiating) pain, numbness, or tingling? ☐ **NO** ☐ **YES**

Referred pain to: _____

Referred numbness to: _____

Referred tingling to: _____

List any factors that aggravate the pain:

☐ exercise ☐ climbing stairs ☐ coughing ☐ driving ☐ sneezing ☐ walking
☐ standing ☐ sitting ☐ other aggravating factors: _____

List any factors that relieve the pain:

☐ applying cold ☐ applying heat ☐ lying down ☐ sitting down ☐ massaging area ☐ walking/moving
☐ other relieving factors: _____

Please note any factors that go along with the pain:

☐ weakness ☐ dizziness ☐ fever ☐ bladder dysfunction ☐ bowel dysfunction
☐ other: _____

List any previous tests related to this problem (in the last 12 months)

☐ CT scan ☐ EMG ☐ Myelogram ☐ Discogram ☐ Labs ☐ MRI
☐ Xray ☐ other: _____

List any previous treatments in the past 12 months (and their effectiveness on the pain):

Medications: (name)

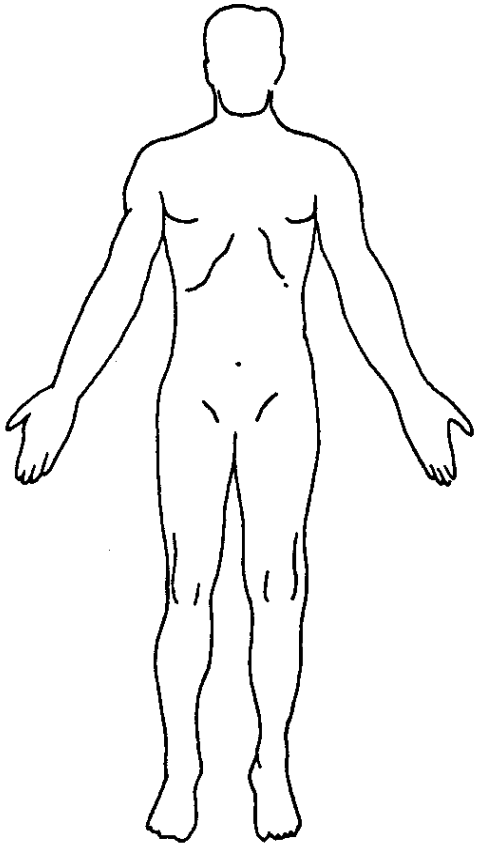
_____	☐ effective	☐ non-effective	
_____	☐ effective	☐ non-effective	
_____	☐ effective	☐ non-effective	
Physical Therapy ☐ resolved	☐ better	☐ worse	☐ no change/unimproved
Injection Therapy ☐ resolved	☐ better	☐ worse	☐ no change/unimproved
Chiropractic ☐ resolved	☐ better	☐ worse	☐ no change/unimproved
Massage ☐ resolved	☐ better	☐ worse	☐ no change/unimproved
Acupuncture ☐ resolved	☐ better	☐ worse	☐ no change/unimproved
Biofeedback ☐ resolved	☐ better	☐ worse	☐ no change/unimproved
Tens Unit ☐ resolved	☐ better	☐ worse	☐ no change/unimproved
Psychologist ☐ resolved	☐ better	☐ worse	☐ no change/unimproved

Other: _____

PAIN HISTORY- Continued

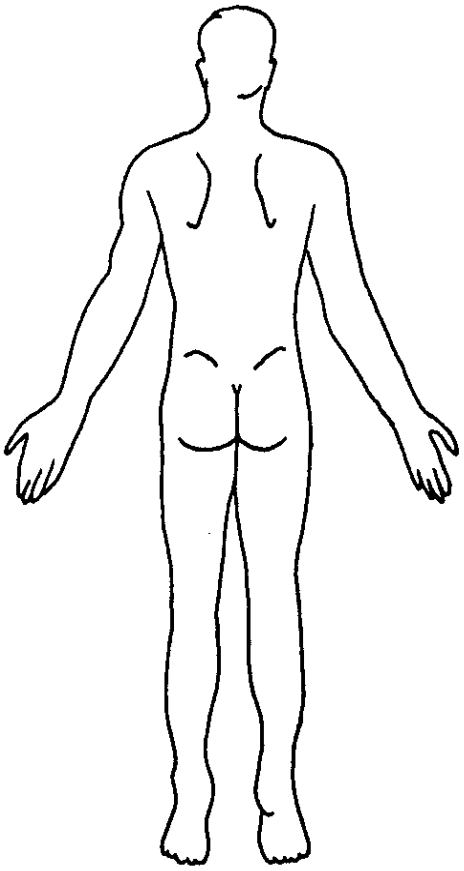
Front

Right **Left**



Back

Left **Right**



Please mark the location(s) of your pain on the diagrams above with an "X." If whole areas are painful, please shade in the painful area.

LITIGATION: Is your pain due to an accident; is litigation (legal suit) or an insurance settlement pending?

YES **NO** (circle one). Please explain briefly:

Patient's Signature: _____ Date: _____

Scanned signature(s) shall suffice as the legal signature(s)