

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: _____

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 Whom 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 whom (name of doctor/chiropractor/other): _____

9. List all past/present medical problems:

Date	Problem	Doctor/Hospital

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10. List all previous surgeries, illnesses, broken bones, etc:

Date	Description	Doctor/Hospital

11. List prior injuries that resulted in medical/chiropractic care (i.e., work-related, motor vehicle accidents, etc.):

Date	Description	Doctor/Hospital

12. List ALL Medications, Vitamins/Herbal remedies you are taking:

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

13. Allergies to Medications? Yes No; List Allergies: _____

14. 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 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	

15. **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

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

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

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

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 _____

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

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 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 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 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: _____

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

17. **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
- 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?

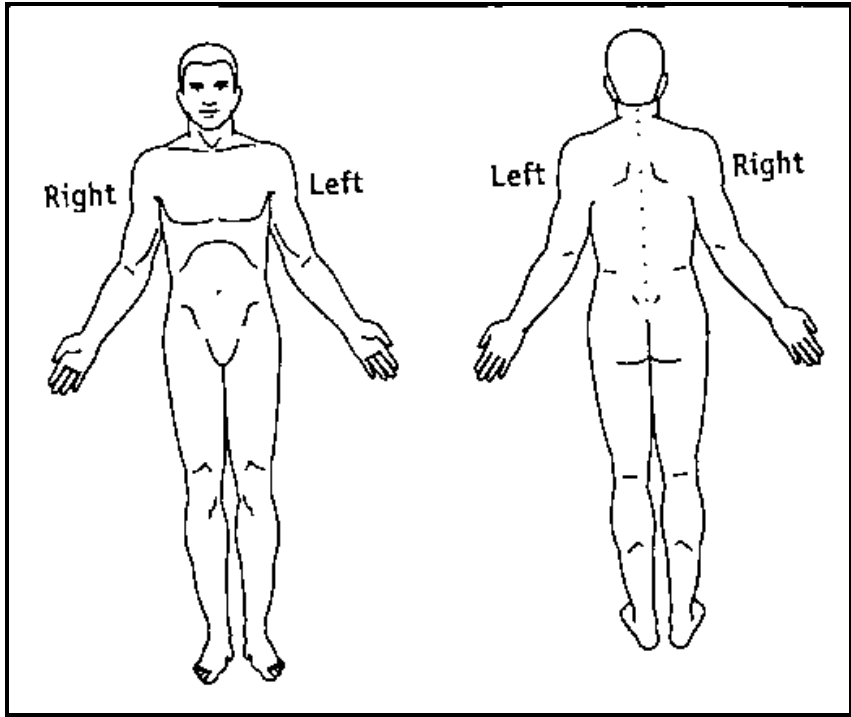
18. **Permanent Impairment:**

- 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?
 - Decrease the pain by at LEAST _____ %
 - 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? _____

19. 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, please indicate type of compensation:
 - Medical Expenses Property Damage Bodily Injury Other _____

20. On the diagram below, please indicate the location of your pain by **shading** the areas where you feel pain, and putting an “**X**” on the area that hurts the MOST.



16. Identify all activities that most DECREASE your pain: Changing Body Positions Frequently
 Walking Standing Sitting Resting Stretching Taking Hot Showers Applying Ice Packs
 Using Prescription Medication Using Over-the-Counter Medication Other _____

17. 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%

18. During the last 24 hours has the pain interfered with your ability to walk?

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

19. Pain interferes with normal work (include work outside the home, as well as housework).

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

20. Pain interferes with sleep?

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

21. Pain interferes with appetite?

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

22. Pain interferes with your mood?

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

23. Pain interferes with relations with other people?

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

24. Pain interferes with enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

25. Pain interferes with concentration?

0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

26. Do other people know when you are in pain? (Check all that apply)

- Family Members Never Sometimes Always Don't know
 Friends Never Sometimes Always Don't know
 Co-workers Never Sometimes Always Don't know

27. Check the comment that best describes your work status:

- Not working at all Have some lost work time
 Working, but unable to do all job duties Doing all regular job duties, but with PAIN
 Doing all regular job duties without difficulty

28. Since your pain started, have you been feeling any of the following: (Check all that apply)

- Tense Nervous Irritable Angry Forgetful Unable to Concentrate Tearful
 Sad Suicidal All of the Above None of the Above

29. If you could decrease your pain, what would you determine would be an acceptable or reasonable goal?

(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

30. Check the appropriate level of activity with each of the functions listed below:

Task or Activity

Lift up to 5 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 10 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 20 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 30 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 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