Pain Management Comprehensive Intake Form History and Physical Page 1

Please take a few minutes to complete this worksheet; This Information will help us in providing your care.

Name: _____
Date of Birth: _____ Sex: _____
Height: _____ Weight: _____
Phone Number: _____

Medical History:

Have you ever had or been told you have (Check all that apply)

Cardiovascular:
[] Chest Pain or Angina
[] Heart Disease
[] MI, Heart Attack, Blocked artery
[] Congestive heart failure
[] High Blood Pressure
[] Peripheral vascular disease
[] Abnormal heart beat
[] Pacemaker
[] Angioplasty or heart cath
[] Rheumatic fever
[] Damaged heart valve

Neurological:
[] Epilepsy or seizures
[] Fainting spells or dizziness
[] Stroke
[] Headaches / Migraines

Gastrointestinal:
[] Ulcers, heartburn, reflux
[] Diverticulitis or Colitis
[] Other: _____
Cancer: _____

Other:
[] Chronic Numbness or pain
[] Depression or Anxiety
[] Other Nervous problems
[] Dentures [] Partial Plate

Respiratory:
[] Asthma
[] Shortness of Breath
[] Emphsema
[] TB

Metabolic:
[] Diabetes
[] Thyroid disease
[] Adrenal gland problem
[] Steroid use

Liver/Kidney/Blood:
[] Kidney disease
[] Shunt, graft, fistula
[] Dialysis
[] Liver disease
[] Gallbladder
[] Hepatitis (Type ____)
[] Anemia
[] Easy Bruising or bleeding

[] Anticoagulants (Blood Thinners)
[] Back injury or nerve damage
[] Skin Condition _____
[] Arthritis, Rheumatism
[] Glasses [] Hearing aid

Social/Family History: Marital Status S M D W Separate
Mother: Living / Deceased Cause: _____
Father: Living / Deceased Cause: _____
Alcohol _____ Drinks per day Other drug use: _____

Employment Status:
[] Employed Part Time
[] Self Employed
[] Unemployed for other reasons
[] Employed Full time
[] Retired
[] Unemployed due to pain
[] Disability
Occupation: _____

Are there any legal/occupational issues pending in regard to your pain condition?
Yes or No. If yes what is it? _____

With whom do you live? [] Self [] Spouse [] Children
[] Parents [] Friends [] Other

Allergies: **Reaction:**
_____
_____
_____
_____

Have you or any of your blood relatives ever Had a reaction to anesthesia? Yes or No

All medications you take at home:
Medication: Dose: How often:
_____
_____
_____
_____
_____
_____
_____

Previous Surgeries (Please include date)
_____
_____
_____
_____
_____
_____
_____
_____
_____

Any problems with surgery or anesthesia?
Yes or No _____
_____

ROS: Please check the box if you are currently having any of the following:
[] Fever, Weight loss, Sweats
[] Cough, Sputnum production, wheeze
[] Weakness or paralysis of arms and legs
[] Headaches How often? _____
[] Dizziness, vision change, lightheadedness
[] Swelling or Rash _____
[] Abdominal Pain
[] Change in bowel habits, Nausea
[] Chest Pain, Palpitations
[] Pregnant or Possibly pregnant?

Pain Management Comprehensive Intake Form History and Physical Page 2

Where is most of your pain? _____

_____

Does it go anywhere else? Yes or No
If yes so where? _____
When did your pain start? _____
How long have you had this pain? _____
Did it start _____ Gradually Suddenly _ Not sure

How often do you experience this pain?
_____ Constant _____ Comes and Goes

Is your pain getting _____ Better _____ Worse
_____ Staying the same

Have you had any X-Rays or MRIs done? Yes or No
If yes so, where at? _____

_____

Check what most describes your plan?

[] Aching	[] Cramping	[] Dull
[] Hot/Burning	[] Numbing	[] Pins/Needles
[] Pressure	[] Sharp	[] Shooting
[] Stabbing	[] Throbbing	[] Tingling

Rate your pain at its worst:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Rate your pain at its best:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Rate your pain on average:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Rate your pain at the moment:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

What makes your pain worse?

[] Bending	[] Changing Position
[] Defecation	[] Going up stairs
[] Heat	[] Going down stairs
[] Increased Activity	[] Lying Flat
[] Lifting	[] Movement
[] Sitting long time	[] Sneezing
[] Standing long	[] Standing straight
[] Turning to the left	[] Turning to the right
[] Turning side to side	[] Walking

What Makes your pain better?

[] Assistive devices	[] Changing Position
[] Cold	[] Exercise
[] Heat	[] Injections
[] Massage	[] Lying Flat
[] Manipulation	[] Medication
[] Physical Therapy	[] Rest
[] Sitting	[] Standing
[] Walking	

What treatments have you tried?

[] Exercise	[] Massage
[] Chiropractic	[] Acupuncture
[] Brace	[] Physical Therapy
[] Heat	[] Ice
[] Nerve Block	[] Biofeedback
[] TENS Unit	[] Traction
[] Psychologist	[] Psychiatrist
[] Surgery	

. . . . . .

What medications have you tried (Circle)
NSAIDS: Aspirin, Ibuprofen, Advil, Metrin
Relaxants: Flexeril, Valium, Xanax, Ativan
Sleep Medicines: Ambien, Restoril, Benadryl
Antidepressants: Elgril, Amitriptyline, Prozac, Effexor, Zoloft, Deseryl, Paxil, Pamelor.
Narcotics: Vicodin, Darvocet, Tylenol, Tylox, Codeine, Percocet, Percoden, MS Contin, Oxy, Demerol, Morphine, Dilaud, Methadone.
Neuropathic Medication: Neurontin, Klonopin, Tegretol, Dilantin, Baclofen, Ultram

[] **Smoking:** Now or Past
_____ Packs per day

On the diagram, please shade in the areas where you have pain?