91 Gregory Lane, Suite 13, Pleasant Hill, CA 94523
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NEW PATIENT PAIN HSTORY

Patient's Name: _____ Date:_____

Date of Birth:_____ Age:_____ Sex: ☐Male ☐Female

Pain Complaint:_____

Approximately when did this pain begin? _____

Describe your pain:

☐Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp

☐Cramping ☐ Numbness ☐ Spasm ☐ Throbbing

☐Dull ☐ Shock-like ☐ Squeezing ☐ Tiring/Exhausting

☐Tingling/Pins and Needles ☐ Other: _____

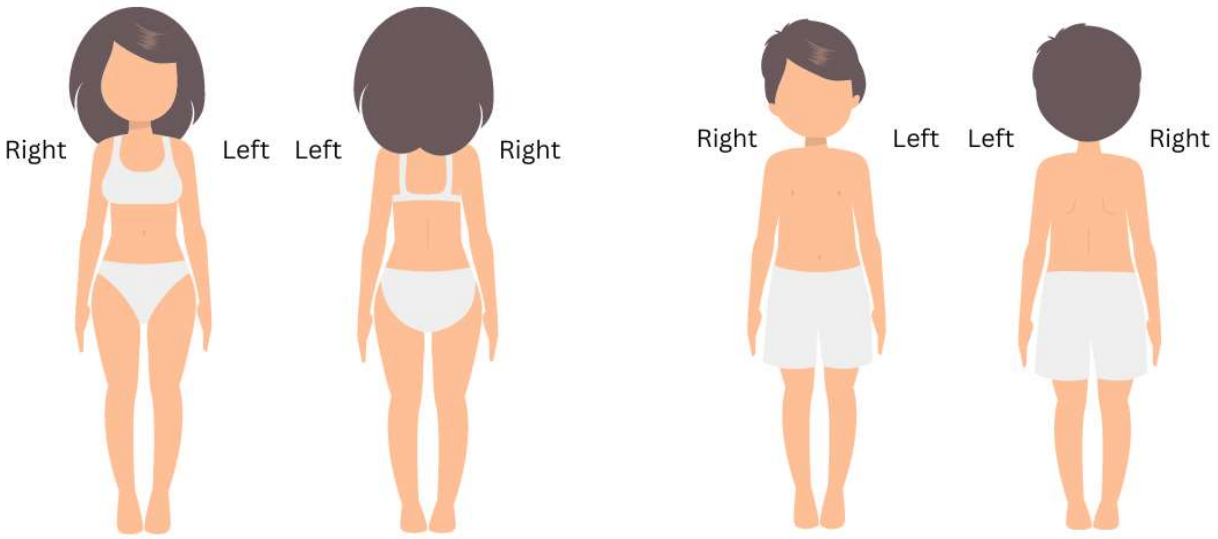
_____

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

When is your pain at its worst? ☐ Morning ☐ During the day ☐ Evenings ☐ Middle of the night

My Pain is improved by… ☐ Sitting ☐ Standing ☐ Laying down ☐ Flexion (bending forward) ☐ Extension (bending back)

Use this diagram to indicate areas where you have your pain.



WOMAN MAN

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Please use the pain scale described below to rate your pain for the question below:

_____ What number on the pain scale (0-10) best describes your pain **right now**?

_____ What number on the pain scale (0-10) best describes your pain **most of the time?**

_____ What number on the pain scale (0-10) best describes your pain **worst pain**?

_____ What number on the pain scale (0-10) best describes your pain **least pain**?

Mark all of the following diagnostic tests you have had that are related to your current pain complaints.

☐ MRI of the _____ Date: _____ Facility: _____

☐ X-ray of the _____ Date: _____ Facility: _____

☐ CT scan of the _____ Date: _____ Facility: _____

☐ EMG/NCV study of the _____ Date: _____ Facility: _____

☐Other diagnostic testing _____ Date: _____ Facility: _____

Mark all of the following pain treatments you have undergone prior to today's visit:

☐ Chiropractic ☐ Physical Therapy ☐ Message ☐ Acupuncture ☐ Spine Surgery ☐ Psychological Therapy

☐ Discogram *(Check all levels that apply)* - ☐ Cervical ☐ Thoracic ☐ Lumbar

☐ Epidural Steroid Injection *(Check all levels that apply)* - ☐ Cervical ☐ Thoracic ☐ Lumbar

☐ Joint Injections – Area/Nerve(s) _____

☐ Medical Branch Blocks or Facet Injections *(Check all levels that apply)* - ☐ Cervical ☐ Thoracic ☐ Lumbar

☐ Nerve Blocks – Area/Nerve(s) _____

☐ Radiofrequency Ablation *(Check all levels that apply)* - ☐ Cervical ☐ Thoracic ☐ Lumbar

☐ Spinal Stimulator *(Check one)* - ☐ Trial Only ☐ Permanent Implant

☐ Trigger Point Injection – Where? _____

☐ Vertebroplasty / Kyphoplasty – Levels (s)? _____

☐ Have you had any pain related surgeries? ☐ Discectomy ☐ Laminectomy ☐ Fusion

Benefits: ☐ None ☐ Moderate ☐ Good ☐ Excellent

☐ Other: _____

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PAST MEDICAL HISTORY

Do you currently or have you ever had any of the following?

YES	NO	YES	NO	YES	NO
☐	☐ Heart Murmur	☐	☐ Shortness of breath	☐	☐ Gastritis or ulcers
☐	☐ Palpitations	☐	☐ Bronchitis	☐	☐ Hiatal Hernia
☐	☐ Heart Attack	☐	☐ TB	☐	☐ Thyroid Disease
☐	☐ Stroke	☐	☐ Asthma	☐	☐ Diabetes
☐	☐ Irregular Heart Beat	☐	☐ Emphysema	☐	☐ Kidney Problems
☐	☐ High Blood Pressure	☐	☐ Sleep Disturbance	☐	☐ Liver Disease
☐	☐ Angina (Chest Pain)	☐	☐ Sleep Apnea	☐	☐ Difficulty Urinating
☐	☐ Seizures	☐	☐ Migraine Headaches	☐	☐ Hepatitis
☐	☐ Arthritis	☐	☐ Weight Change	☐	☐ HIV or exposure
☐	☐ Cancer *(if yes, please explain)*				

Others that are not listed please explain below:

_____

_____

_____

_____

_____

PAST SURGICAL HISTORY

Please list any surgical produces you have had done in the past, including the date, type, and any pertinent details.

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

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ALLERGIES:

Do you have any known drug allergies? ☐ Yes ☐ No

Are you allergic to: ☐ Iodine ☐ Latex ☐ Tape ☐Selfish ☐ Eggs ☐ Sulfa

If so, please list all medications you are allergic to:

Medication Name	Allergic Reaction Type

CURRENT MEDICATIONS:

Please list ALL medications you are currently taking, include dosage and the name of doctor prescribing.

Medication Name	Dose/ Strength	Frequency Taken	Ordering Physicians

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PSYCHIATRIC HISTORY:

Are you currently seeing a psychiatrist or psychologist? ☐ Yes ☐ No

If yes, whom? _____

Have you had any recent through or ideations of suicide or harming others? ☐ Yes ☐ No

SOCIAL HISTORY:

What is your occupation? _____

What is your current work status? _____

Do you smoke? ☐ Yes ☐ No If yes, what and how much? _____

Do have drink alcohol? ☐ Yes ☐ No If yes what and how much? _____

Do you take Street drugs? ☐ Yes ☐ No If yes what and how much? _____

Have you ever abused narcotic or prescription medication? ☐ Yes ☐ No If yes, what? _____

Marital Status: ____ Single ____ Married ___ Divorced ___ Widowed

Are you involved in litigation regarding this pain? _____Yes _____ No

_____ _____

Reviewed by **Date**

NOTES: _____

_____

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