Dr. Evans New Patient Pain History Form

Please PRINT and fill out completely.

Date: ☐☐/☐☐/☐☐☐☐ **Med Record #** ☐☐☐☐☐☐

Name:_____**Nickname:** _____ **Age:**_____**yrs. D.O.B**_____

Height:☐**ft** ☐☐**in Weight:**☐☐☐**lbs Sex:** ◯**Male** ◯**Female Are you or could you be pregnant?** ◯**Yes** ◯**No**

Occupation:_____ **Employer:**_____

Where do you live?_____**Preferred Language:**_____

Who referred you to this office? If more than one, please note.

◯**Dr.**_____ ◯**PA/NP**_____
◯**Friend/Word of Mouth**_____ ◯**Physical Therapist**_____
◯**Family Member**_____ ◯**Other**_____

HISTORY OF CARE

Who is your primary care physician?_____ **Location:**_____
Address:_____**Phone:**_____

Please list any other doctors, clinics, or hospitals you have seen for your current pain complaint:

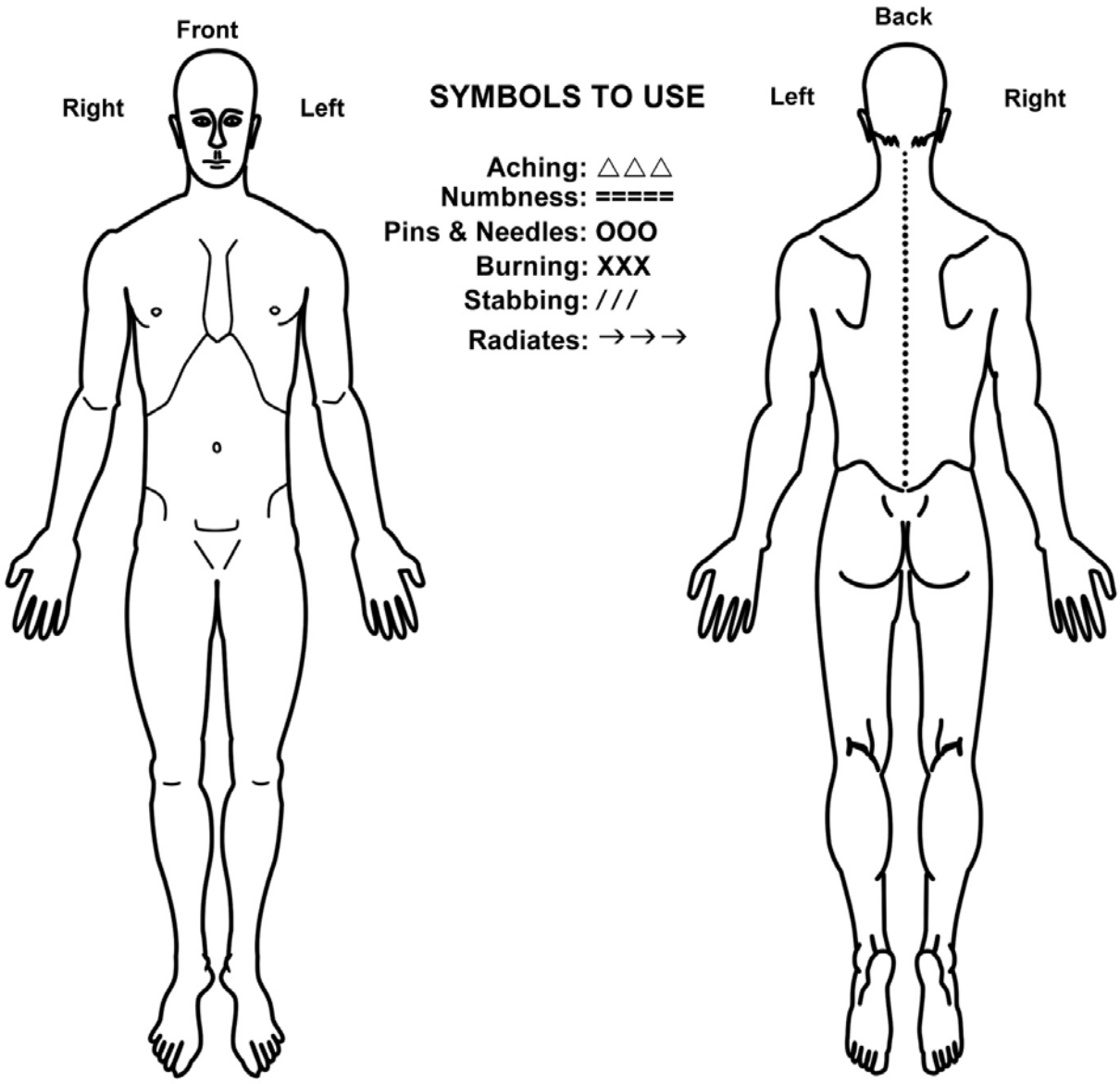
Name	City	Date of First Visit	Continuing Care? Y/N

Have you had any of the following tests/studies?

	Date (month/year)	What facility? (clinic/hospital)
◯ **X-Rays**	_____	_____
◯ **MRI Scan**	_____	_____
◯ **CT Scan**	_____	_____
◯ **EMG/NCV**	_____	_____
◯ **Discogram**	_____	_____
◯ **EKG**	_____	_____
◯ **Blood Tests**	_____	_____
◯ **Other**	_____	_____

PATIENT PAIN DRAWING

Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates, include all affected areas.



SYMBOLS TO USE

Aching: △△△
Numbness: =====
Pins & Needles: OOO
Burning: XXX
Stabbing: ///
Radiates: →→→

Mark where any symptoms (pain, numbness, weakness, etc.) exist on average (most of the time) and at their worst.

Current pain		None										Unbearable
	Average	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

HISTORY OF CURRENT PAIN PROBLEM

List your chief complaints or main problems, with the most severe first:

1._____
2._____
3._____

Describe all details of any accident, incident, or the way these problems began:

_____
_____
_____

Is the injury CHRONIC? ◯Yes ◯No If YES, how long has it been going on for?_____

Is the injury NEW as a result of a specific injury? ◯Yes ◯No If YES, date of injury/accident:____/___/_____

Is your pain the result of the following : ◯ Work Injury? ◯Motor Vehicle Accident What state?_____

What treatments have you tried?

◯ Nothing ◯ Decreased Activity ◯ Physical Therapy. If so, when did you start?_____

◯ Exercise ◯ Acupuncture ◯ Chiropractic ◯ Bracing ◯ Ice

◯ Medications (OTC, Rx): _____

◯ Other: _____

◯ Injections (Synvisc, Steroid, Botox) which type, body part and when?_____

◯ Spinal Injections/Rhizotomies. If so, what types of injections have you had and at what level(s)?_____

When was your last spinal injection(s)? _____

What % of relief did it provide you for the FIRST 3 HOURS? _____

How long did the relief last after that? _____

CURRENT SYMPTOMS

What time of day is your pain at its worst?	**◯ Morning ◯ Afternoon ◯ Evening ◯ Night ◯ N/A**	
Does the pain wake you up at night?	**◯ Yes**	**◯ No**
In the past six months have you experience:	**◯ Fever**	**◯ Weight Loss_____lbs**
	◯ Chills	**◯ Night Sweats**
How would you describe your pain?	**◯ Constant**	**◯ Constant, but worse with activity**
	◯ Intermittent	**◯ Intermittent, but worse with activity (comes and goes)**
Do you have full control of your bladder?	**◯ Yes**	**◯ No**
Do you have full control of your bowels?	**◯ Yes**	**◯ No**

MIGRAINES/CHRONIC HEADACHES

○ ***NONE: If no history of migraines/headaches, skip this page***

How long have you had migraines/headaches? _____

How many headaches do you get per month? _____

How many hours do your headaches typically last? _____

Where do you get your headaches? _____

What is the intensity of your headaches? Pain scale 0-10/10: _____

What do you do when you have a headache? _____

What other symptoms do you get with your headaches (nausea, aura, etc)?

_____

What medications do you take NOW for your headaches (list any/all)?

_____

What medications have you taken in the past that do not work now?_____

Have you tried ANY of the following medications or others like them? (please circle)

Rescue Medications/Triptans: **Imitrex, Frova, Maxalt, Relpax, Treximet, Zomig, Rizatriptan, Amerge**

Angiotensin-converting enzyme inhibitors/angiotensin II receptor blockers: **Losartan, Valsartan, Lisinopril**

Anti-depressants: **Amitriptyline, Nortryptiline, Effexor, Paxil, Prozac**

Anti-epileptics: **Gabapentin, Lyrica, Topiramate, Valproic Acid, Depakote**

Beta Blockers: **Atenolol, Metoprolol/Lopressor, Propanolol/Inderal, Timolol**

Calcium Channel Blockers: **Diltiazem, Nifedipine, Verapamil**

Others**: Excedrin, Fioricet, Fiorinal, Stadol, Midrin, Cafergot, Butalbital**

Muscle Relaxers

NSAIDs: **Advil, Ibuprofen, Aleve**

Botox Injections

Others: **_____**

ALLERGIES

Please list any allergies or adverse reactions you have to medications:

Medication	Reaction (What happens?)

MEDICATIONS

Please list ALL medications you are currently taking, including prescription and over the counter:

Medication	Dosage	Frequency (how many pills in 24 hrs)

Are you currently taking blood thinning medication? (Aspirin, Warfarin, Plavix, etc.) ◯**Yes** ◯**No**

PAST MEDICAL HISTORY

Check if you currently are being treated for or have been diagnosed with:

	When?		When?
◯ **High blood pressure**	_____	◯ **Immune Disorders**	_____
◯ **Diabetes**	_____	◯ **Osteoporosis**	_____
◯ **Liver Disease**	_____	◯ **Kidney Disease/Problem**	_____
◯ **Heart Disease or Attack**	_____	◯ **Seizures**	_____
◯ **Stroke**	_____	◯ **Sleep Apnea**	_____
◯ **High Lipids (cholesterol, etc.)**	_____	◯ **Arthritis**	_____
◯ **Ulcer Disease**	_____	◯ **Thyroid**	_____
◯ **Gastritis**	_____	◯ **Tuberculosis**	_____
◯ **Reflux Disease (GERD)**	_____	◯ **Psoriasis**	_____
◯ **Asthma**	_____	◯ **Polio**	_____
◯ **Depression**	_____	◯ **Rheumatic Fever**	_____
◯ **Bipolar Disease**	_____	◯ **Gout**	_____
◯ **Other Psychiatric**	_____ __	◯ **Herpes Simplex**	_____
◯ **Blood clot/Bleeding disorder**	_____	◯ **Other**_____	
◯ **Chronic Regional Pain Syndrome**	_____		

Have you ever had a history of blood clots or pulmonary embolus? ◯Yes ◯No
If Yes, when and what type?

_____

Have you ever had a MRSA Staph/Infection? ◯Yes ◯No If Yes, when?

_____

Do you have any type of active infection, systemically or locally? ◯Yes ◯No If Yes, please explain: _____

Do you have heart problems/pacemaker/heart valve? ◯Yes ◯No If YES, please explain:

_____

Do you have lung problems that require you to take medication? ◯Yes ◯No If YES, please explain:_____

Do you have a history of ANY type of cancer? ◯Yes ◯No If YES, please explain:

_____

SURGERIES

Please list all <u>SPINE</u> surgeries you have had in the past:

Type of Surgery	Date	Surgeon

Please list all <u>OTHER</u> surgeries you have had in the past:

Type of Surgery	Date	Surgeon

FAMILY HISTORY

Is your father alive? ◯Yes ◯No If YES, age and any major medical problems?_____

If NO, age at time of death?_____ What major medical problems did he have?_____

Is your mother alive? ◯Yes ◯No If YES, age and any major medical problems?_____

If NO, age at time of death?_____ What major medical problems did she have?_____

Any Siblings? ◯Yes ◯No How many?_____

SOCIAL HISTORY

Marital Status: ◯ **Married** ◯ **Single** ◯ **Divorced** ◯ **Widowed** ◯ **Living with other**

Education level achieved: ◯ **Grade school** ◯ **Jr. High** ◯**High School** ◯ **College** ◯ **Post.Graduate**

Do you CURRENTLY smoke cigarettes? ◯**Yes** ◯**No** **Number of years smoked:**_____

Packs per day (please choose the closest): ◯ **< 1/2** ◯**1/2** ◯**1** ◯**2** ◯**>2**

Did you FORMERLY smoke cigarettes? ◯**Yes** ◯**No** **Number of years smoked:**_____ **Quit Date:**___/__/___

Packs per day (please choose the closest): ◯ **< 1/2** ◯**1/2** ◯**1** ◯**2** ◯**>2**

Do you use any other tobacco products? ◯**Yes** ◯**No** **What kind?**_____ **Quantity:**_____

Do you use any recreational drugs? ◯**Yes** ◯**No** **What kind?**_____

Do you drink alcohol? ◯**Yes** ◯**No** **Drinks per day:**_____**Drinks per week:**_____**Years:**_____

DO YOU HAVE OR HAVE YOU HAD an unhealthy relationship with alcohol? ◯**Yes** ◯**No**

Type of alcohol consumption: ◯ **Beer** ◯ **Wine** ◯**Mixed Drinks**

What sports/recreational activities do you participate in (or used to before you had pain)?

_____

WORK HISTORY

Are you currently: ◯ **Employed** ◯ **Unemployed** ◯ **Retired** ◯ **On Sick Leave** ◯ **On Disability** ◯ **Other**

Has your job changed since your symptoms started? ◯**Yes** ◯**No** ◯**Not working**

If you are at a different job or not working, did your symptoms play a role in your job change or decision not to work? ◯**Yes** ◯**No**

If you are working, are you on: ◯ **Normal duties** ◯ **Light duties**

If you are on light duty, did your current symptoms play a role? ◯**Yes** ◯**No**

Are you applying for disability? ◯**Yes** ◯**No**

Please describe your job:_____

WORKMAN'S COMPENSATION HISTORY

IS THIS A WORKERS COMPENSATION CASE? ◯**Yes** ◯**No**

Have you had any PRIOR workers compensation injuries? ◯**Yes** ◯**No** **How many?**_____

Please list any prior workers compensation cases/injuries:

Date	Area Injured	Time Off Work	Who Treated You?

Were you at work when your symptoms began? ◯**Yes** ◯**No**

Did you have a specific accident/injury while at work to cause your symptoms? ◯**Yes** ◯**No**

Prior to your WC injury, how long had you been employed by that company?_____

Do you currently have an attorney for this episode? ◯**Yes** ◯**No**

CAR ACCIDENTS

WERE YOUR SYMPTOMS CAUSED BY A CAR ACCIDENT? ◯Yes ◯No

Have you had any PRIOR car accidents? ◯Yes ◯No If YES, how many?_____

Please list:

Date	Area Injured	Time Off Work	Who Treated You?

Do you currently have an attorney for this episode? ◯Yes ◯No

REVIEW OF SYSTEMS

Check YES or NO in the following area. If YES, please describe:

1. CONSTITUTIONAL

- **A. Recent weight change?** ◯Yes ◯No _____
- **B. Change or loss of appetite?** ◯Yes ◯No _____
- **C. Fevers?** ◯Yes ◯No _____
- **D. Chills?** ◯Yes ◯No _____
- **E. Night sweats?** ◯Yes ◯No _____
- **F. Weakness fatigue?** ◯Yes ◯No _____

2. EYES

- **A. Vision change?** ◯Yes ◯No _____
- **B. Glasses/contacts?** ◯Yes ◯No _____
- **C. Glaucoma?** ◯Yes ◯No _____
- **D. Eye infections (iritis)?** ◯Yes ◯No _____
- **E. Loss of vision?** ◯Yes ◯No _____

3. EARS, NOSE, AND THROAT

- **A. Decrease or loss of hearing?** ◯Yes ◯No _____
- **B. Ear ache or infection?** ◯Yes ◯No _____
- **C. Tinnitus (ringing in ear)?** ◯Yes ◯No _____
- **D. Nasal stuffiness/discharge?** ◯Yes ◯No _____
- **E. Nosebleeds?** ◯Yes ◯No _____
- **F. Sore throat?** ◯Yes ◯No _____
- **G. Hoarseness?** ◯Yes ◯No _____
- **H. Dental problems?** ◯Yes ◯No _____
- **I. Dentures?** ◯Yes ◯No _____
- **J. Difficult swallowing?** ◯Yes ◯No _____

4. CARDIOVASCULAR

- **A. Chest pain?** ◯Yes ◯No _____
- **B. Shortness of breath?** ◯Yes ◯No _____
- **C. Palpitations?** ◯Yes ◯No _____
- **D. Swelling in the legs?** ◯Yes ◯No _____
- **E. PLEASE LIST MOST RECENT HEART TESTS WITH NAME OF FACILITY, DATE, AND PHONE NUMBER**

_____
_____
_____
_____
_____
_____

5. RESPIRATORY

- **A. Cough?** ◯Yes ◯No _____
- **B. Wheezing/asthma?** ◯Yes ◯No _____
- **C. Pneumonia or bronchitis?** ◯Yes ◯No _____
- **D. Shortness of breath?** ◯Yes ◯No _____

6. GASTROINTESTINAL

- **A. Abdominal pain?** ◯Yes ◯No _____
- **B. Nausea or vomiting?** ◯Yes ◯No _____
- **C. Constipation?** ◯Yes ◯No _____
- **D. Diarrhea?** ◯Yes ◯No _____
- **E. Heartburn/acid reflux?** ◯Yes ◯No _____
- **F. Rectal bleeding or black, tarry stools?** ◯Yes ◯No _____

7. GENITOURINARY

- **A. Increase frequency urination?** ◯Yes ◯No _____
- **B. Pain/burning with urination?** ◯Yes ◯No _____
- **C. Frequency infection of urine?** ◯Yes ◯No _____
- **D. Incontinence (loss of control)?** ◯Yes ◯No _____
- **E. Reduced force of urination?** ◯Yes ◯No _____

8. MUSCULOSKELETAL

- **A. Muscle aches?** ◯Yes ◯No _____
- **B. Joint pains/stiffness?** ◯Yes ◯No _____
- **C. Swelling of joints?** ◯Yes ◯No _____

9. SKIN

- **A. Rash?** ◯Yes ◯No _____
- **B. Lumps or sores?** ◯Yes ◯No _____
- **C. Changes in hair or nails?** ◯Yes ◯No _____
- **D. Dryness?** ◯Yes ◯No _____
- **E. Ulcers?** ◯Yes ◯No _____
- **F. Abdominal scars?** ◯Yes ◯No _____

10. NEUROLOGICAL

- **A. Headaches?** ◯Yes ◯No _____
- **B. Fainting/blackouts?** ◯Yes ◯No _____
- **C. Tremors/involuntary movements?** ◯Yes ◯No _____
- **D. Numbness, tingling?** ◯Yes ◯No _____
- **E. Dizziness?** ◯Yes ◯No _____
- **F. Muscle weakness?** ◯Yes ◯No _____

11. PSYCHIATRIC

- **A. Depression?** ◯Yes ◯No _____
- **B. Mood swings?** ◯Yes ◯No _____
- **C. Anger?** ◯Yes ◯No _____
- **D. Nervousness/anxiety?** ◯Yes ◯No _____

12. ENDOCRINE

- **A. Excessive thirst or hunger?** ◯Yes ◯No _____
- **B. Hot/cold intolerance?** ◯Yes ◯No _____
- **C. Hot flashes?** ◯Yes ◯No _____

13. HEMATOLOGICAL

- **A. Easy bruising or bleeding?** ◯Yes ◯No _____
- **B. Past blood transfusions?** ◯Yes ◯No _____