Name:_________________________ Date:________

Pain Management of North Idaho

Pain history

When did your pain start? ____________(date)
If there is not a specific date, did the pain start: ____gradually after an injury
____gradually without an injury
____suddenly with an injury
____suddenly without an injury
Describe the severity of your pain: ____mild ____moderate ____severe ____incapacitating
My pain is: ____changing ____improving ____fluctuating ____resolved ____stable ____worse
My pain: ____is always there ____occurs intermittently ____is infrequent
Where is your pain? ____
Does your pain radiate? Where? ____
Check which words best describe your pain: ____aching ____burning ____deep ____diffuse
____discomforting ____dull ____localized ____numb ____piercing ____sharp ____shooting
____stabbing ____superficial ____throbbing ____other:________________________
My pain is aggravated by: ____walking up stairs ____bending ____changing positions ____coughing
____daily activities ____having a bowel movement ____bending backwards ____bending forwards
____jumping ____lifting ____lying down ____rolling over in bed ____pushing ____running ____sitting
____sneezing ____standing ____twisting ____walking
____other:______________________________
My pain is relieved by: ____nothing ____exercise ____heat ____ice ____injections ____lying down
____massage ____movement ____OTC medications ___prescribed pain meds
____physical therapy ____spontaneously ____stretching ____rest ____sitting
____other:______________________________

Other symptoms associated with your pain:

	Yes	No
Loss of bladder control		
Inability to urinate		
Loss of bowel control		
Loss of balance		
Numbness		
Weakness		
Weight change		

Name:________________________ Date:________

Medications:

Medication name	Strength (i.e., mg)	Directions (i.e., one pill two times a day, at bedtime, etc.)

Do you take any supplements? ____yes ____no
If yes, what are they? ____

Allergies:

Allergy/medication	Reaction

Name:________________________ Date:________

Review of Systems

Please check the box if you have the symptom listed

Constitutional		**Cardiovascular**		**Neurological**		**Musculoskeletal**	
Chills		Chest pain		Dizziness		Back pain	
Fever		Edema		Numbness		Joint pain	
Night sweats		Palpitations		Weakness		Joint swelling	
Weight gain		**Gastrointestinal**		Gait disturbance		Neck pain	
Weight loss		Abdominal pain		Headache		**Integumentary**	
HEENT		Blood in stools		Memory loss		Hives	
Hearing loss		Constipation		Seizures		Itching	
Sore throat		Diarrhea		Tremors		Rash	
Psychatric		Loss of appetite		**Hematologic**		**Respiratory**	
Anxiety		Nausea		Easy bleeding		Chronic cough	
Depression		Vomiting		Easy bruising		Cough	
Insomnia		**Genitourinary**		Swollen lymph nodes		Known TB exposure	
		Blood in urine				Shortness of breath	
		Urinary frequency				Wheezing	
		Incontinence					
		Urinary retention					

Name:________________________ Date:________

Past Medical History

Please check the box if you have or have had the medical problem listed

Condition	☐	Condition	☐	Condition	☐	Condition	☐
Anemia		Colon cancer		Hypertension		Rheumatoid arthritis	
Angina		Congestive heart failure		Kidney failure		Seizure disorder	
Arrhythmia		COPD		Liver disease		Spinal cord tumor	
Asthma		Coronary artery disease		Lung cancer		Thyroid disease	
Atrial fibrillation		Diabetes		Migraine headaches		Tremor	
Blood clots		Fibromyalgia		Multiple sclerosis		Breast cancer	
Brain tumor		Hepatitis C		Parkinson's disease		Other:	
Cerebrovascular accident		HIV/AIDS		Peripheral nerve disorder		Other:	
Cirrhosis		Hyperlipemia		Renal disease			

Past Surgical History

Please check the box if you have had the surgery listed

Surgery	☐	Surgery	☐	Surgery	☐	Surgery	☐
Anesthesia reaction		Carpal tunnel release		Knee replacement		Cesarian section	
Aneurysm clipping		Cataract extraction		Laminectomy		D&C	
Angioplasty with stent		Cerebral shunt		LASIK		Hysterectomy	
Angioplasty		Gall bladder removal		Muscle biopsy		Mastectomy	
Appendectomy		Colectomy		ORIF		Myomectomy	
Arthroscopy knee		Colostomy		Pacemaker		Breast reduction	
Arthrodesis		Discectomy		Small bowel resection			
Back surgery		Gastric bypass		Spinal infusion pump		Other:	
CABG		Hernia repair		Thyroidectomy		Other:	
Carotid endarterctomy		Hip replacement		Tonsillectomy			

Name:____________________________ Date:_________

Diagnostic studies

Please list any diagnostic studies you have had related to your pain

Study type (MRI, X-ray, etc.)	Date	Where performed

Family History

Please list any significant family history

Diagnosis	Mother	Father	Sister	Brother	Family history of
Alcoholism					
Heart disease					
Cancer					
Depression					
Diabetes					
Fibromyalgia					
High blood pressure					
Mental illness					
Substance abuse					
Other:					
Other:					
Other:					
Other:					
Other:					

Name:__________________________ Date:________

Social History

Smoking history: ____current every day smoker ____current some day smoker ____former smoker ____never smoked
I drink alcohol: ____never ____daily ____weekly ____monthly ____yearly ____occasionally ____rarely ____socially
My highest level of education is: ____elementary school ____high school ____some college ____college graduate ____trade school ____technical school ____graduate/professional school
Marital status: ____married ____separated ____divorced ____single ____widowed/widower ____life partner
Previously widowed: ____no ____yes
Previous divorce: ____no ____yes
Who lives in your home with you: ____
Children: ____#sons ____#daughters
My activity level is: ____sedentary ____moderate ____vigorous
I exercise ____ times per week.
Type of exercise: ______________________________________
My religious affiliation is: ________________________
My occupation is: _____________________________
My employment status is: ____full-time ____part-time ____self-employed ____unemployed ____retired ____laid off ____active military ____active military reserve ____disabled ____private disability ____social security disability ____student

Alcohol Use

Age started: ________
Sought treatment for alcohol abuse: ____no ____yes
Involved in a 12 step program: ____no ____yes
Have you had withdrawal problems, seizures or blackouts from alcohol: ____no ____yes
Emergency medical attention required due to intoxication: ____no ____yes
Family history of alcoholism: ____no ____yes

Drug Use

Use drugs: ____no ____yes ____formerly
Type of drug use: ____
Sought treatment for drug abuse: ____no ____yes
Involved in a 12 step program: ____no ____yes
Emergency medical treatment required due to drug use: ____no ____yes
Family history of drug abuse: ____no ____yes

Psychiatric History

Do you have a history of psychiatric illness: ____no ____yes
Do you have a history of suicidal thoughts: ____no ____yes
Do you have a history of homicidal thoughts: ____no ____yes
Do you see a psychiatrist: ____no ____yes
If yes, do we have your permission to communicate with your psychiatrist: ____no ____yes
Name: ______________________________
Do you see a therapist: ____no ____yes
If yes, do we have your permission to communicate with your therapist: ____no ____yes
Name: ______________________________
Family history of psychiatric illness: ____no ____yes
Have you ever been a victim of sexual abuse: ____no ____yes