Primary Care Physician: ___________________________ Referring Physician: ___________________________

How did you find out about our pain clinic?  □ Friend □ MD □ Newspaper □ Web

Where is your pain? ____________________________________________________________

When did your pain start? ___________________________ □ Gradually □ Suddenly

How did it begin? (car accident, fall, job related injury, etc)? __________________________

What do you believe is causing the pain? ___________________________________________

What best describes your pain:

- □ Ache
- □ Crushng
- □ Intense
- □ Numb
- □ Stabbing
- □ Tender
- □ Burn
- □ Bull
- □ Itchy
- □ Pinching
- □ Steady
- □ Unbearable
- □ Cold
- □ Heavy
- □ Miserable
- □ Sharp
- □ Tear
- □ Weak
- □ Constant
- □ Hot
- □ Nagging
- □ Spasm
- □ Throbbing

Please indicate on the diagram below, where your pain is located:

Please circle the appropriate number

<table>
<thead>
<tr>
<th>Pain level now:</th>
<th>NONE</th>
<th>MILD</th>
<th>MODERATE</th>
<th>SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>5</td>
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<td>10</td>
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</tbody>
</table>

Does the pain affect?

- Sleep: ..... □ Trouble falling asleep □ Trouble staying asleep
- Appetite: ..... □ Weight loss □ Weight gain □ Stayed the same
- Physical Activity: ..... □ Decreased □ Increased □ Stayed the same

Relationships with others (irritability): ____________________________

Emotions (i.e. anger, sadness): _________________________________________

Concentration: ___________________________________________________________

Pain is worse: ..... □ On Awakening □ End of Day □ During Night
We want to know what affects your pain:

**Which of these activities improve your pain?**

- [ ] Bending Backward
- [ ] Bending Forward
- [ ] Cold
- [ ] Coughing
- [ ] Eating
- [ ] Exercise
- [ ] Getting out of bed
- [ ] Heat
- [ ] Ice
- [ ] Laying down
- [ ] Noise
- [ ] Relaxation
- [ ] Sexual Activity
- [ ] Sitting
- [ ] Standing
- [ ] Touch
- [ ] Walking
- [ ] Weather Changes
- [ ] Other: ____________________________________________

**Which of these activities make your pain worse?**

- [ ] Bending Backward
- [ ] Bending Forward
- [ ] Bowel Movement
- [ ] Changing Positions
- [ ] Cold
- [ ] Coughing
- [ ] Driving
- [ ] Heat
- [ ] Lifting
- [ ] Lying down
- [ ] Sexual Activity
- [ ] Sitting
- [ ] Stairs
- [ ] Standing
- [ ] Stress
- [ ] Touch
- [ ] Walking
- [ ] Weather Changes
- [ ] Other: ____________________________________________

**Therapies Tried:**

- [ ] Acupuncture
- [ ] Chiropractor
- [ ] Hypnosis
- [ ] Massage
- [ ] Other Pain Clinics
- [ ] Other: ____________________________________________
- [ ] Tens Unit
- [ ] Traction
- [ ] Swimming

**Medication Treatment History**

<table>
<thead>
<tr>
<th>Medication for Pain (name)</th>
<th>Dosage and Frequency</th>
<th>Start Date</th>
<th>Stop Date</th>
<th>Why Stopped</th>
<th>How much helped (%)</th>
<th>Side effects?</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

**Have you undergone Nerve Blocks/Pain Procedures?**

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Type</th>
<th>Where</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
## Past Medical History - Personal:
(Please provide an explanation below for any checked items)

<table>
<thead>
<tr>
<th>☐ Anemia</th>
<th>☐ Cancer</th>
<th>☐ Heart Problems</th>
<th>☐ Seizure / Epilepsy</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Angina</td>
<td>☐ COPD/Emphysema</td>
<td>☐ Hepatitis/Jaundice</td>
<td>☐ Sleep Apnea</td>
</tr>
<tr>
<td>☐ Anxiety</td>
<td>☐ Muscle / Skeletal Problems</td>
<td>☐ High Blood Pressure</td>
<td>☐ Stroke / TIA</td>
</tr>
<tr>
<td>☐ Asthma</td>
<td>☐ Depression</td>
<td>☐ HIV</td>
<td>☐ Thyroid</td>
</tr>
<tr>
<td>☐ Back Problems</td>
<td>☐ Diabetes</td>
<td>☐ Lung Problems</td>
<td>☐ Tuberculosis (TB)</td>
</tr>
<tr>
<td>☐ Bleeding Disorder</td>
<td>☐ Fibromyalgia</td>
<td>☐ Migraines</td>
<td>☐ Ulcers</td>
</tr>
<tr>
<td>☐ Blood Clots</td>
<td>☐ GERD / Heartburn</td>
<td>☐ Mitral Valve Prolapse</td>
<td>☐ Venereal Disease</td>
</tr>
<tr>
<td>☐ Bowel Problems i.e. colitis/ constipation</td>
<td>☐ Heart Attack</td>
<td>☐ Neurological Pain</td>
<td>☐ Other</td>
</tr>
</tbody>
</table>

---

### Past Surgeries/Illnesses/Hospitalizations (describe):

---

### Allergies:

---

### Review of Systems (check all that apply) As relates to your health

<table>
<thead>
<tr>
<th>☐ Abnormal Heartbeat</th>
<th>☐ Frequent Constipation</th>
<th>☐ Hot or cold spells</th>
<th>☐ Stomach Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Blackouts</td>
<td>☐ Frequent diarrhea</td>
<td>☐ Loss of Hearing</td>
<td>☐ Swollen Ankles</td>
</tr>
<tr>
<td>☐ Burning on Urination</td>
<td>☐ Frequent Headaches</td>
<td>☐ Morning Cough</td>
<td>☐ Toothache</td>
</tr>
<tr>
<td>☐ Calf Cramps w/walking</td>
<td>☐ Frequent Rash</td>
<td>☐ Nausea or Vomiting</td>
<td>☐ Ulcers</td>
</tr>
<tr>
<td>☐ Change of Vision</td>
<td>☐ Frequent Urination</td>
<td>☐ Nervous Exhaustion</td>
<td>☐ Other</td>
</tr>
<tr>
<td>☐ Difficulty Starting Urination</td>
<td>☐ Get up more than once every night to urinate</td>
<td>☐ Nosebleeds</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Difficulty Swallowing</td>
<td>☐ Gum Trouble</td>
<td>☐ Poor appetite</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Ear Pain</td>
<td>☐ Heart or Chest Pain</td>
<td>☐ Reading Glasses</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Fever or Chills</td>
<td>☐ Hemorrhoids</td>
<td>☐ Recent Weight change</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Frequent Belching</td>
<td>☐ Hoarseness</td>
<td>☐ Seizures</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Shortness of Breath</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Women only:**

<table>
<thead>
<tr>
<th>☐ Irregular Periods</th>
<th>☐ Menopause</th>
<th>☐ Spine Problems</th>
<th>☐ Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Stroke</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Other</td>
<td></td>
</tr>
</tbody>
</table>

---

### Family History (check all that apply) ☐ None Apply

<table>
<thead>
<tr>
<th>☐ Addiction Disorders</th>
<th>☐ Chronic Pain</th>
<th>☐ Kidney Trouble or Stones</th>
<th>☐ Spine Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Alcoholism</td>
<td>☐ Diabetes</td>
<td>☐ Mental Illness</td>
<td>☐ Stroke</td>
</tr>
<tr>
<td>☐ Arthritis</td>
<td>☐ Gout</td>
<td>☐ Respiratory Problems</td>
<td>☐ Other</td>
</tr>
<tr>
<td>☐ Bleeding Disorders</td>
<td>☐ Heart Trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Cancer</td>
<td>☐ High Blood Pressure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Social History:
Are you currently:  ☐ Single  ☐ Married  ☐ Divorced  ☐ Widowed
With whom do you live? ____________________________________________________
How has pain affected your life? ___________________________________________
Education, last grade completed: __________________________________________
Are you presently working?  ☐ No  ☐ Yes/Occupation: ___________________________
Any legal actions related to pain condition?  ☐ No  ☐ Yes __________________________
Are you disabled?  ☐ No  ☐ Yes/Reason __________________________________________
Are you able to take care of yourself?  ☐ Yes  ☐ No _______________________________
What activities help you relax? ______________________________________________
What are your hobbies? _____________________________________________________
Do you exercise?  ☐ No  ☐ Yes _________________________________________________
Do you have any animals?  ☐ No  ☐ Yes _________________________________________
Religious/Culture/Spiritual practices affecting hospital treatment:  ☐ No  ☐ Yes ___________________________

Due to the increase in domestic violence, we ask all adult patients the following:
Do you feel unsafe or afraid of anyone (i.e. your partner, a relative or anyone else)?  ☐ Yes  ☐ No
Is anyone trying to control or hurt you (i.e. control who you see and talk to, where you go, what your wear, how you spend your money etc)?  ☐ Yes  ☐ No ___________________________________________
Are you interested in support from a social worker?  ☐ Yes  ☐ No ___________________________

Substance Use:
Use of tobacco products:  ☐ Never smoked  ☐ Quit Smoking  ☐ Still smoking  ☐ Chew Tobacco  ☐ Pipe
How much do/did you smoke? ________/day  How many years do/did you smoke? ________
Do you wish to quit?  ☐ Now  ☐ Soon  ☐ Eventually  ☐ Never ___________________________
How much caffeine do you drink daily (include coffee, tea, colas): ___________________________
Use of Alcohol:  ☐ No  ☐ Yes-Amount/Frequency: ___________________________

Which of the following drugs or substances, if any, have you used in the past (check all that apply)?
☐ Cocaine  ☐ Other Illicit Drugs (specify) ___________________________________________
☐ Heroin  ☐ Marijuana ____________________________________________________
Are you using any of the drugs or substances below (check all that apply) and when last used?
☐ Cocaine-when: ___________________________  ☐ Other Illicit Drugs (specify) and when:
☐ Heroin-when: ___________________________  ☐ Marijuana-when: ___________________________

Form Filled out by (please print): _____________________________________________
Signature: __________________________________ Date/Time: __________________________