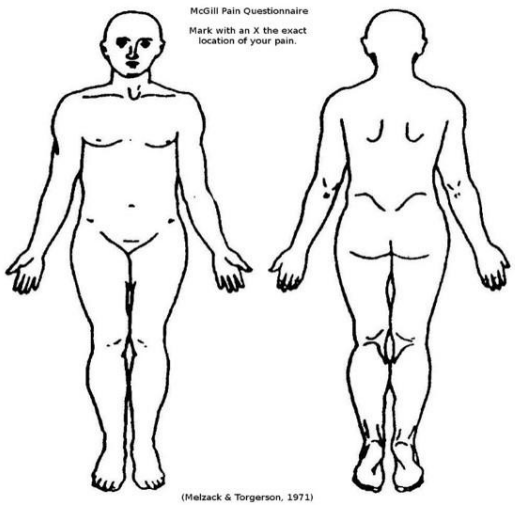
SOUTH CENTRAL PAIN CENTER

Patient Name: _____ Date of Birth:_____

Drug Allergies/Sensitivities: _____

PAIN HISTORY

1. Where is the pain? On the diagram, shade in the areas where you feel pain. Put an **X** on the area that hurts the most.



2. Where does pain radiate or spread to?

Head	Upper back	Lower back
Neck	Ribs	Buttocks
Shoulder	Chest	Hip
Arm	Abdomen	Thigh
Elbow	Pelvis	Knee
Forearm	Groin	Calf
Wrist		Ankle
Hand		Foot

3. How did your pain start? ☐ Sudden ☐ Gradual
   Is pain related to an injury or trauma? ☐ Yes ☐ No
   Explain when and how your pain started _____

_____

_____

4. Rate your pain by circling the number that best describes your pain at its **worst** in the last week.
   0 1 2 3 4 5 6 7 8 9 10

5. Rate your pain by circling the number that best describes your pain at its **least** in the last week.
   0 1 2 3 4 5 6 7 8 9 10

6. Rate your pain by circling the number that best describes your pain on **average**.
   0 1 2 3 4 5 6 7 8 9 10

7. Rate your pain by circling the number that best describes your pain **right now**.

0 1 2 3 4 5 6 7 8 9 10

8. How would you describe your pain ?

☐ Aching	☐ Pressure	☐ Burning	☐ Sharp
☐ Throbbing	☐ Tight	☐ Dull	☐ Numb
☐ Shooting	☐ Tingling	☐ Squeezing	☐ Cramping
☐ Stabbing	☐ Other_____		

9. Circle activities that make your pain **better**?

Activity / movement	Elevation	Distraction
Inactivity / rest	Compression	Meditation
In the evening	Wearing a brace	Massage
In the morning	Ice	Stretching
Medications–prescription	Heat	Nothing
Medications–OTC		

10. Circle activities that make your pain **worse**?

Activity / movement	Bending	Heat
Inactivity / rest	Lifting	Cold
Sitting	Twisting	Touch / pressure
Standing	Driving	Negative mood
Walking	Sexual activity	After surgery / medical treatment
Laying down	Eating	Nothing, it's constant
Sleeping	Certain positions	Nothing, it's spontaneous
Other:_____		

11. Do you experience any of the following?

Incontinence of the bladder or bowels?	No	Yes
Severe weakness in the legs?	No	Yes
Numbness between the legs?	No	Yes

12. What treatments have you tried?

Physical therapy	NSAIDs (ibuprofen, naproxen)	Yoga
Chiropractic	Muscle relaxants	Stretching
Massage	Anti-convulsants (gabapentin, lyrica)	Nutritional Supplements
Acupuncture	Anti-depressants	Bracing
Heat / Ice	Opioids	Other:_____

13. Have you been to physical therapy? ☐ No ☐ Yes, last visit was: _____

If yes, how much did PT help?

Continue to next page...

No Improvement

Mild improvement

Moderate improvement

Significant improvement

Helped with activity performance, but pain is still an issue

Couldn't complete PT because pain was too severe

Attempted PT, but it made the pain worse

Other: _____

14. Do you use opioids for pain relief? ☐ No ☐ Yes

If yes, how much relief does your medication provide?

Complete relief

At least 75% relief

At least 50% relief

Less than 50% relief

None

If yes, what is the frequency of your bowel movements?

Daily _____ time(s) per week

If yes, do you experience any side effects, such as:

Nausea Vomiting Constipation Mental Cloudiness Fatigue

Other: _____

Side effect severity: None Mild Moderate Severe

Are side effects well-controlled? ☐ Yes ☐ No

15. Circle one number that describes how, during the past week, pain has interfered with your:

General Activity

0 1 2 3 4 5 6 7 8 9 10

Mood

0 1 2 3 4 5 6 7 8 9 10

Walking Ability

0 1 2 3 4 5 6 7 8 9 10

Normal Work

0 1 2 3 4 5 6 7 8 9 10

Relationships with Other People

0 1 2 3 4 5 6 7 8 9 10

Sleep

0 1 2 3 4 5 6 7 8 9 10

Enjoyment of Life

0 1 2 3 4 5 6 7 8 9 10

PAIN HISTORY: Check (√) the box that best describes your past treatment and its effects on your pain

Treatment	Effect of Treatment			
	Helped	Didn't Help	Made Pain Worse	Not Tried
Physical Therapy:_____	☐	☐	☐	☐
Chiropractic	☐	☐	☐	☐
Massage	☐	☐	☐	☐
Water/Pool therapy	☐	☐	☐	☐
Acupuncture/Acupressure	☐	☐	☐	☐
TENS unit	☐	☐	☐	☐
Spine injections (type) _____	☐	☐	☐	☐
Muscle injections	☐	☐	☐	☐
Joint injection	☐	☐	☐	☐
Other nerve injection _____	☐	☐	☐	☐
Other professional treatment_____	☐	☐	☐	☐
Surgery (type and date)_____	☐	☐	☐	☐
Behavioral therapy.	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

SLEEP:

Overall quality ☐ Good ☐ Fair ☐ Poor Total hours at night _____ Total hours at a time _____

Difficulty falling asleep:	☐ Never	☐ Sometimes	☐ Always
Frequent nighttime awakenings:	☐ Never	☐ Sometimes	☐ Always
Difficulty falling asleep if awakened:	☐ Never	☐ Sometimes	☐ Always

Sleep Medications you are using:_____ Past Sleep Medications: _____

MOOD:

Please describe your general mood over the last week:

☐ Normal/neutral	☐ Depression	☐ Irritable	☐ Guilty	☐ Hopeless
☐ Generally happy	☐ Helpless	☐ Anxiety	☐ Worried	☐ Up and down
☐ Sad	☐ Lack of enjoyment	☐ Fearful	☐ Angry	☐ Other_____

Do you have a history of mood problems (anxiety, depression, other)? _____
Are you currently being treated for mood problems?_____ By who?_____

Medications for mood you are currently using:_____
Past Mood Medications: _____

FUNCTION

Currently I am able to:

Care for my basic needs (bathe, dress, feed)	☐ Always	☐ Most of the time	☐ Sometimes	☐ Never
Care for myself at home (cook, clean, laundry)	☐ Always	☐ Most of the time	☐ Sometimes	☐ Never
Drive short distances and run errands	☐ Always	☐ Most of the time	☐ Sometimes	☐ Never
Do light activity (yard work, walk 15 minutes)	☐ Always	☐ Most of the time	☐ Sometimes	☐ Never
Do moderate activity (30 minutes or more)	☐ Always	☐ Most of the time	☐ Sometimes	☐ Never

On a scale from 0 (bed-bound) to 100 (doing everything you want to do) please rate your overall function:_____%

Please list any activity restrictions _____
Do you do any regular physical activity? _____ Please describe _____

My goal is to be able to_____

***PAIN MEDICATIONS** Please list medications and doses you are currently using for your pain:______________________

____

____

Previous Pain Medications	Did it help	Why was it stopped
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:
	☐Yes ☐Some ☐No	☐Didn't help ☐Side effects? List:

Medication Goal____

***PHARMACY** Name, Address and Phone Number of your preferred pharmacy:________________________________

____

***PAST MEDICAL HISTORY** Check (√) any major medical problems you presently have or have had:

☐ Alcohol abuse	☐ Congestive heart failure	☐ Hiatal hernia	☐ Seizure
☐ Anesthesia problems	☐ COPD/Emphysema	☐ High blood pressure	☐ Stroke
☐ Anxiety	☐ Depression	☐ HIV	☐ Thyroid
☐ Arthritis	☐ Diabetes	☐ Irregular heartbeat	☐ TIA (mini-stroke)
☐ Asthma	☐ Dizziness	☐ Kidney problems	☐ Transfusion
☐ Bleeding disorder	☐ Fainting	☐ Liver problems	☐ Ulcer
☐ Bowel problems	☐ Heart attack	☐ Migraine/ Headaches	☐ Urinary problems
☐ Cancer	☐ Heart valve problems	☐ Reflux disease	☐ Other________
☐ Chest pain	☐ Hepatitis	☐ Pancreatitis	☐ Other________

***PAST SURGICAL HISTORY**

☐ Appendectomy	☐ Hernia repair	☐ Joint surgery____________	☐ Other_____________
☐ Coronary bypass	☐ Hysterectomy	☐ Joint replacement:________	☐ Other_____________
☐ Gall bladder removed	☐ Tonsils & Adenoids	☐ Spine Surgery:___________	☐ Other_____________

***FAMILY HISTORY** List illnesses that run in your family

Family (Name)	Living / Dead	Major Illnesses
Father		
Mother		
Siblings - # sisters______ brothers______		
Children - #daughters______ sons______		

DIAGNOSTIC TESTS: Which of the following tests for this pain have been done (if more than one list most recent test)?

Diagnostic Test	Body Part	Approximate Date	Where was it done?
X-Rays			
CT scan			
MRI scan			
EMG/Nerve study			
Other______________			

***SOCIAL / OCCUPATIONAL HISTORY**

Do you smoke or use tobacco? ☐ No ☐ Yes ☐ Quit How much?_____ For how long?_____
Do you drink alcohol? ☐ No ☐ Yes ☐ Quit How much?_____ For how long?_____
Do you use illegal drugs? ☐ No ☐ Yes ☐ Quit What type?_____ For how long?_____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried
Children: ☐ None #daughters_____ #sons_____ # people living in the home_____
Living Situation ☐ Alone ☐ With spouse ☐ With family ☐ With child(ren ☐ With parents ☐ Roomates

Employment: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disability since_____ ☐ Retired ☐ Homemaker
Employer_____ For this pain are you involved in ☐ Litigation ☐ Workers Compensation
If you are not working, do you plan to: ☐ Return to your old job ☐ Take a different job ☐ Not return to work

Please list any other concerns or things we should know about your pain_____

REVIEW OF SYSTEMS: In the last month have you had:

General	**YES**	**NO**
Activity change	☐	☐
Appetite change	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Unexpected weight change	☐	☐
Head/Neck:		
Neck Pain	☐	☐
Neck Stiffness	☐	☐
Hearing Loss	☐	☐
Ringing in your ears	☐	☐
Eyes		
Eye Discharge	☐	☐
Eye Pain	☐	☐
Eye Redness	☐	☐
Respiratory		
Chest Tightness	☐	☐
Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Cardiovascular		
Chest Pain	☐	☐
Leg Swelling	☐	☐
Palpitations	☐	☐
GI		
Abdominal Pain	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Nausea	☐	☐
Vomiting	☐	☐

Endocrine	**YES**	**NO**
Cold Intolerance	☐	☐
Heat Intolerance	☐	☐
Genitourinary		
Difficulty Urinating	☐	☐
Painful Urination	☐	☐
Flank Pain	☐	☐
Musculoskeletal		
Joint Pain	☐	☐
Back Pain	☐	☐
Joint Swelling	☐	☐
Muscle Pain	☐	☐
Skin		
Color Change	☐	☐
Rash	☐	☐
Wound	☐	☐
Neurological		
Dizziness	☐	☐
Headaches	☐	☐
Numbness	☐	☐
Seizures	☐	☐
Weakness	☐	☐
Hematologic		
Easy bruising	☐	☐
Swollen lymph nodes	☐	☐
Psychiatric		
Confusion	☐	☐
Depressed mood	☐	☐
Nervous/anxious	☐	☐