Copper Valley Medical
Caring, Compassionate Healing

Pain History

Patient Name: _____ **Date of Birth/Age:** _____ **Date:** _____

What is the primary reason for your visit?

__**Acute Pain** (Recent Onset)

__**Chronic Pain** (Lasting at least three months

Date of Onset? _____

What caused your pain?

- Motor Vehicle Accident __
- Work Accident __
- Sports Injury __
- Congenital/Birth __
- Other:_____

Have you seen other doctors for this? Y N

__Primary Care __ER __ Chiro __ Physical T

If yes, Diagnosis:_____

What treatment or medication have you had for your pain?

_____

_____

_____

Where is your pain?		**Severity of Pain** (1-10)
• Headache		1…3…6 7 8 9 10
• Neck		1…3…6 7 8 9 10
• Upper Back		1…3…6 7 8 9 10
• Mid Back		1…3…6 7 8 9 10
• Lower Back		1…3…6 7 8 9 10
• Knee	R L	1…3…6 7 8 9 10
• Ankle	R L	1…3…6 7 8 9 10
• Foot	R L	1…3…6 7 8 9 10
• Shoulder	R L	1…3…6 7 8 9 10
• Elbow	R L	1…3…6 7 8 9 10
• Wrist	R L	1…3…6 7 8 9 10
• Hand	R L	1…3…6 7 8 9 10
• Abdomen		1…3…6 7 8 9 10
• Other_____		1…3…6 7 8 9 10

What is your level of pain now? 1---5----10

Does the pain keep you from doing what you want or need to do? __Y __N

What is the HIGHEST level of pain you have had since it began? 1---5----10

What is the HIGHEST level of pain you have had in the past week? 1---5----10

For Women of Childbearing Potential Only

- Are you, or could you be, pregnant? Y N
- If yes, do you plan to breastfeed? Y N
- If not pregnant, do you plan on becoming pregnant in the near future? Y N
- If you are not pregnant and do not have plans for a pregnancy, what form of prevention do you practice?

  _____

Current Medications:

Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____

Current Supplements:

Supplement: _____ Dose: _____ Frequency: _____
Supplement: _____ Dose: _____ Frequency: _____
Supplement: _____ Dose: _____ Frequency: _____

Known Drug Allergies:

Medication: _____ Reaction: _____ Last Taken: _____
Medication: _____ Reaction: _____ Last Taken: _____
Medication: _____ Reaction: _____ Last Taken: _____

If this is the result of an accident:

- **Have you contacted your insurance carrier, e.g., auto insurance for a motor vehicle accident? __Y __N**
- **Have you contacted an attorney to represent you in a legal action for this? __Y __N**
- **Do you desire to defer payment for our services until the accident has been settled __Y __N**
  If yes, you must provide us with the contact information for your insurance representative or attorney

Signature of Patient

_____ _____
Signature Date