Phone:
Fax:

Visit - Chronic Pain Hx -

Welcome to our practice. We are committed to providing you with the best medical care possible. To help us provide this care, please fill out the information below to the best of your ability. Thank you for trusting us with your healthcare needs.

What questions, concerns, or problems would you like to discuss during your visit?

List any allergies, including your reaction (i.e.. short of breath, hives.)

[CurrentAllergies]

List any current prescription medications you are taking.

[CurrentMeds]

Date and Time of Your Last Dose of Pain Medication

List your medical and surgical history.

Pain History

Phone:
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Visit - Chronic Pain Hx - New -

Date Pain First Started

Have you ever been addicted to prescription drugs, alcohol or illegal drugs?

Does anyone in your family have a history of substance abuse or addiction?

Have you ever been in a treatment program for alcohol or drug abuse?

Have you been diagnosed with Attention Deficit Disorder (ADD), Obsessive Compulsive Disorder (OCD), Bipolar, Schizophrenia, or Depression?

Are you currently on disability? **Are you applying for disability?**

Are you receiving Worker's Compensation? **Are you applying for Worker's Compensation?**

Do you have litigation pending against an employer or individual due to an accident or injury?

What is the location(s) of your pain?

Select all that apply when describing your pain.

Phone:
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❒	Aching	❒	Gnawing	❒	Penetrating	❒	Stabbing
❒	Burning	❒	Miserable	❒	Pressure	❒	Tender
❒	Dull	❒	Nagging	❒	Sharp	❒	Throbbing
❒	Exhausting	❒	Numb	❒	Shooting	❒	Unbearable

How often do you have pain?

What makes your pain worse?

❒	Cold	❒	Rest	❒	Standing
❒	Exercise	❒	Sex	❒	Touch
❒	Heat	❒	Sitting	❒	Walking

Other

What makes your pain better?

Have you had a previous diagnosis for this pain?

Do you have numbness, tingling, or weakness in arms/legs?

Have you had any changes in bowel or bladder function?

If yes, describe.

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On a scale of 0-10, 10 being the worse, how would you rate your current pain?

Is your pain the result of a work-related or auto-related injury?

If yes, what was the date of the injury?

Have you had a previous injury or surgery to this area in the past?

What is your pain level without medication?

What is your pain level with medication?

In the past week rate your pain level at its least.

In the past week, how has pain interfered with the following activities?

General Activity

Mood

Walking Ability

Normal Work (including both work outside the home and housework)

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Relationships with Others

Sleep

Quality of Life

How many physicians have been involved in the treatment of your pain?

How many emergency room visits have you had in the last year for pain?

In the last week, what percent of relief have pain treatments or medications provided?

Rate your comfort level.

Rate your functional status.

Pain Treatments

Select which nerve blocks, injections, or procedures you have had performed. If you don't remember the name use other.

Block, Injection, Procedure	How Many	Dates Performed
❒ Cervical (neck) Epidural Steroid Injection		
❒ Lumbar Epidural Steroid Injection		

Phone:
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❒ Caudal Epidural Steroid Injection

❒ Facet Joint Block

❒ Facet Joint Denervation

❒ Stellate Ganglion Block

❒ Lumbar Sympathetic Block

❒ Trigger Point Injection

❒ Discogram

❒ Occipital Nerve Block

❒ Intercostal Nerve Block

❒ Spinal Cord Stimulator

❒ Intrathecal Pump

Other

Pain Medication

Do you have some form of pain now that requires medication each and every day?

Have you taken pain medication in the last 7 days?

If you take pain medication, how many hours does it take before the pain returns?

Hours

How do you prefer to take pain medicine?

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How frequently do you take pain medication in a 24-hour period?

List any past pain medications you have taken along with why you stopped.

Current Opioid Therapy

What percent of relief do your opioids provide?

Do you have any side effects from your opioids?

If yes, select all that apply

❒	Appetite Change	❒	Erectile Problems	❒	Menstrual Change	❒	Sleepiness
❒	Constipation	❒	Itching	❒	Nausea	❒	Tooth Decay
❒	Dizziness	❒	Light Headedness	❒	Problems Urinating	❒	Vomiting
❒	Dry Mouth						

Are you any more functional from using opioids?

Has your quality of life improved?

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Name and number of pharmacy listed on opioid bottle.

Name of doctor currently prescribing opioids.

Social History

Select your smoking status.

If you quit smoking, what was the date?

-1

On average how many cigarettes per day do you smoke?

How many years have you smoked?

Have you thought about quitting smoking?

If you have thought about quitting smoking, would you like help to do so?

How often you do drink alcohol?

List any illegal substances you use.

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Select your highest level of education.

Are you currently employed?

If yes, what do you do?

If yes, how many hours per day?

If no, is unemployment due to pain?

Select your current marital status.

Do you have children?

If yes, how many?

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