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Patient History Form

Personal Data (please print)

Date: _____
Name: _____ Birth Date: _____ Age: _____ Ht: _____ Wt: _____
Social Security #: _____ If you consider yourself disabled, please indicate the date of
Drivers License #: _____ onset of your disability : _____
What is your current employment status?: Marital Status: ❒ Married ❒ Single
❒ Full Time ❒ Part Time ❒ Retired ❒ Homemaker ❒ Divorced ❒ Widowed # of times married: _____
❒ Unemployed due to pain Highest level of Education: ❒ Grade School
Date last worked: _____ ❒ High School - Grad. Date: _____ ❒ Voc/Tech/Bus
Occupation: _____ ❒ College Degree _____
Have you changed your job for health reasons?
❒Yes ❒ No
What is your level of physical activity at work?
❒ Highly active ❒ Slightly Active
❒ Moderately Active ❒ Inactive

Have you ever felt like you had to cut down on medication?
❒ Yes ❒ No
Have people annoyed you by criticizing your medication use?
❒ Yes ❒ No

Name of person to contact in case of emergency:
Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (bus.) _____ (home) _____

Have you ever felt guilty about your medication use?
❒ Yes ❒ No
Have you ever needed an eye opener or needed medication to feel normal? ❒ Yes ❒ No

Are you pregnant or is there a chance that you could be pregnant? ❒ Yes ❒ No
Have you or anyone in your family had a problem with an Anesthetic? ❒ Yes ❒ No
Are there any medical problems that run in your family? _____
Do you smoke? ❒ Yes ❒ No
Do you consume alcohol? ❒ Yes ❒ No
Sleep Pattern: _____
Do you exercise? ❒ Never ❒ Rarely ❒ Frequently Type _____
Do you have any emotional or psychological problems that concern you? ❒ Yes ❒ No
Have you ever seen a psychologist or a psychiatrist? ❒ Yes ❒ No
How many times have you been to the emergency room, because of the present pain? _____ Times
What do you want from your treatment? _____
What do you expect from your treatment? _____
If your pain cannot be helped what do you plan to do? _____
List any hobbies or special interests: _____

Health Questionnaire

Drug allergies: ❒ No ❒ Yes, Please List: _____

Current medications: what, if any, medications are you taking now. Please list all medications.

Medication	Why prescribed	Dosage	How Often	Effectiveness: Very/Not at all
1				
2				
3				
4				
5				
6				
7				
8				

Personal Medical History: (Please check and explain)

❒ High Blood Pressure	❒ Diabetes	❒ Glaucoma
❒ Mental Illness	❒ Abnormal Pap Smear	❒ Sexually Transmitted Disease
❒ Heart Disease	❒ Cancer	❒ Seizures
❒ Migraine Headaches	❒ Shortness of Breath	❒ Tuberculosis
❒ Kidney Disease	❒ Asthma	❒ Alcoholism
❒ Ulcers	❒ Fatigue	❒ Gout
❒ Bladder Infection	❒ Stroke	❒ Anemia
❒ Abnormal Bleeding	❒ Dizziness, Fainting	❒ Allergies
❒ Liver Disease	❒ Arthritis	❒ Fibromyalgia
❒ Thyroid Disease	❒ Sexual Dysfunction	❒ Other
❒ Mononucleosis	❒ COPD	❒

Explanation: _____

_____

Check the box that applies to your work experience:

	Almost always	Some of the time	Hardly ever
I am satisfied that I can turn to a fellow worker for help when something is troubling me.			
I am satisfied with the way my fellow workers talk things over with me and share problems with me.			
I am satisfied that my fellow workers accept and support my new ideas or thoughts			
I am satisfied with the way my fellow workers respond to my emotions, such as anger, sorrow or laughter.			
I enjoy the tasks involved in my job.			
Please check the column that indicates how well you get along with your closest or immediate supervisor.			

List any surgeries you have had or hospital admissions:

Type of Surgery or Admission.
1.
2.
3.
4.
5.

CURRENT MEDICAL PROBLEM

Pain History:

Describe in your own words what your pain is like (location, how it feels, is it constant, does it come and go, do you have numbness, etc.) _____

_____

_____

How and when did your pain problem first start? (accident, disease, after surgery, date of onset, etc.)

_____

_____

_____

How much work have you missed since pain onset _____

Do you always have pain at rest? _____

Physician's Comments

(for office use only)

Review of systems:

Constitutional: fever, chills, night sweat, weight gain, weight loss, anorexia, fatigue
Psych: depression, aggression, anxiety, suicidal ideation
GIT: nausea, vomit, diarrhea, constipation, heartburn, melena, hematochezia, abdominal pain
GU: nocturia, polyuria, polydipsia, hematuria, pyuria, incontinence
CVS: chest pain, palpitation, failure
Resp: cough, sputum, hemoptysis, SOB
Blood: bleeding dyscrasias, pallor
Skin: rash, lumps
Metabolic: polyphagia, hot, cold, obesity
Neuro: dizziness, tingling, numbness, syncope, headaches
Eyes: discharge, redness, vision

Alert Oriented: x3 HR BP RR

Mood: depressed, anxious
GPE: well developed, well nourished, well groomed
Scalp: normocehalic, nontraumatic
Eyes: Anemia, Icterus, PERRLA
Ears: no tragal tender, no discharge
Nose: septum central, mucosa pink, no polyps
Tongue: central moist, pink
Neck: supple, trachea central, no thy romegaly, no JVD
Chest: hyperresonant, CTA
Heart: S1S2, no murmur, no gallop
Abdomen: soft, nontender, no organomegaly
Extremeties: no calf tenderness, no edema, no clubbing, no cyanosis, pulses +

Type of pain:

❒ Sharp ❒ Dull Ache ❒ Burning ❒ Throbbing ❒ Tiring
❒ Constant ❒ Intermittent ❒ Tingling ❒ Cutting ❒ Sickening
❒ Pressing, Pulling ❒ Numb ❒ Cramping ❒ Other ❒ Punishing
❒ Stinging ❒ Stabbing ❒ Spasms ❒ ❒ Fearful

Made worse by: ❒ Sitting ❒ Standing ❒ Walking ❒ Sneezing
❒ Coughing ❒ Straining ❒ Flexing ❒ Extension
❒ Light Stroking of Skin ❒ Other

Made better by: ❒ Rest ❒ Sitting ❒ Medication
❒ Other: _____

Time of day your pain is worse: ❒ Morning, on arising ❒ Later in morning
❒ Afternoon ❒ Evening
❒ Bedtime ❒ Night - sleeping hrs.
❒ Pain is always the same
❒ Pain varies - no particular time is worse

Have you had bowel changes: ❒ Yes ❒ No
Bladder changes: ❒ Yes ❒ No
Paralysis: ❒ Yes ❒ No

Have you noticed any of the following changes in the painful area:

❒ Increased nail growth ❒ Skin change ❒ Swelling
❒ Hair growth ❒ Sweating ❒ Goose bumps
❒ Temperature change, if so: ❒ Cold ❒ Hot

Physician's Comments
(for office use only)

Previous Treatment for Pain:	**Yes**	**No**	**Helpful**	**Not Helpful**	**Problem**
Nerve Blocks					
Surgery					
TENS Unit					
Occupational/Physical Therapy					
Biofeedback					
Hypnosis					
Counseling					
Chiropractic					

Which of the following tests have you had to evaluate your pain within the past six months to year?

Test	**Date**	**Results**
X-Ray		
Laboratory/Blood/Urine		
CT Scan		
MRI		
Epidurogram		
Myelogram		
Thermogram		
Bone Scan		
Rectal/Hemoccult		
Other		

Name of Physicians involved in your medical care:

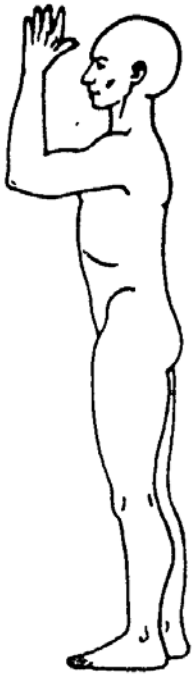
Physician	**Address**	**Phone**

Please complete Pain Chart on next page

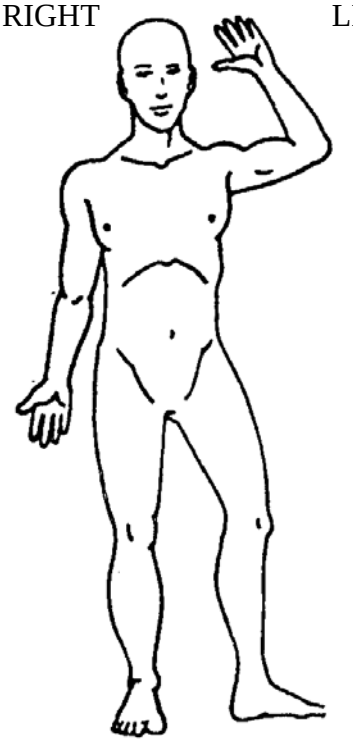
Mark the areas of your pain: (Please complete this page)

RIGHT

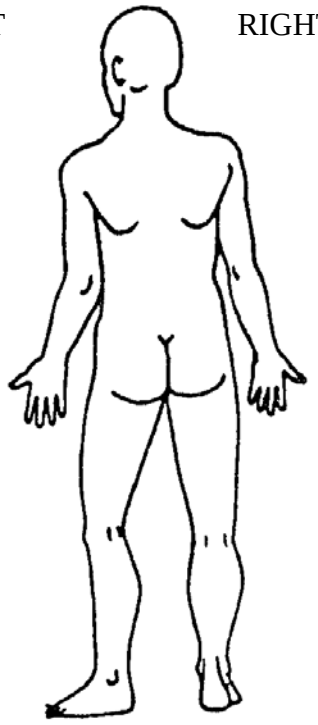
LEFT



RIGHT LEFT



LEFT RIGHT



On a scale of 0 to 10 rate your pain:

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worst Pain Imaginable**

Physician's Comments

(for office use only)

Physical Exam:
Gait: anantalgic/limp/slow/waddling/cane/walker/wheelchair
Coordination: heel knee/shin finger/nose
Cervical Spine: tender/spasm/ROM/spurling/distraction/valsalva
Thoracic Spine:

Lumbar Spine: paravertebral spasm/tender/S.I. joint/scar/gluteal tender/greater trochanter/ROM
Extremities: well built/atrophy/nontender/tender/length equal/unequal/spasticity pulses
FROM/Limited ROM/Phalen's (press)
Tinel's (tap)
hips
knee
ankle
foot
shoulder
elbow
wrist
Sensory: loss of sensation, allodynia, nail change, temp change, hair change, skin change, color, pulses, trigger points
Motor: mass, power, tone, fasciculations, involuntary movement, reflexes

C:5 motor: shoulder abduct
sensory: lateral arm
reflex: biceps
C:6 wrist extension
sensory: lateral forearm
reflex: brachioradialis
C:7 motor: wrist flexion/finger extension
sensory: middle finger
reflex: triceps
C:8 motor: finger flexion
sensory; medial forearm

T:1 motor: finger abd/add
sensory: medial arm

L:4 motor: foot inver
sensory: medial leg
reflex: patellar
L:5 motor: toe exten
sensory: dorsal foot

S:1 motor: foot inver
sensory: lat foot
reflex: achilles

Misc: SLR/Patricks/Hoover/Freiburg (pirifomis)

Head: supraorbital/infraorbital/occipital/auriculo temporal