New Patient Pain History Form

Name: _____ Date of Birth: ____/____/_____ Today's Date: ____/____/_____

Date the Pain Began: ____/____/_____ Reason for visit: _____

_____

_____

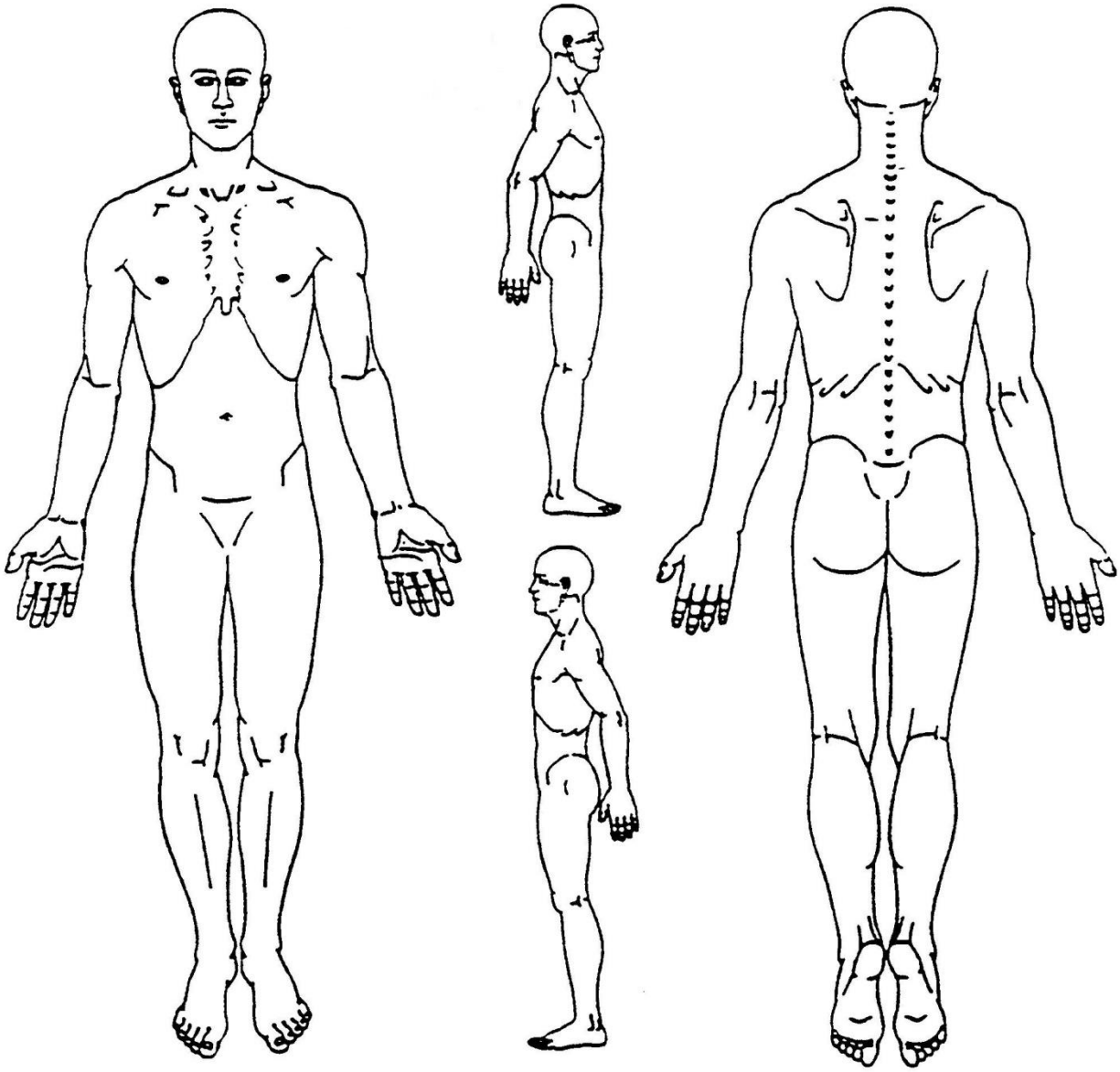
Describe what caused the pain (accident, injury, etc.): _____

_____

_____

Pain

1. Pain/Symptom Description – Mark the affected areas on your body where you feel your typical pain and/or symptom and place a star by where you are most affected.



2. How would you describe the kind of pain/associated symptoms that you have:
   ☐Sharp ☐Stabbing ☐Aching ☐Dull ☐Burning ☐Cramping ☐Pins and needles ☐Throbbing
   ☐ Numbness – If so, where? _____ ☐ Weakness – If so, where? _____
3. Pain compared to when it first started: ☐Improved by _____% ☐Worsened by _____% ☐No Change
4. Pain Severity: If "0" is no pain and "10" is the worst pain imaginable, please note your pain over the <u>past two weeks</u> by circling the appropriate number:

Pain at its worst:	[0 1 2]	[3 4 5 6 7]	[8 9 10]
	Mild	Moderate	Severe
Pain at its least:	[0 1 2]	[3 4 5 6 7]	[8 9 10]
	Mild	Moderate	Severe
Pain on average:	[0 1 2]	[3 4 5 6 7]	[8 9 10]
	Mild	Moderate	Severe

   Pain Frequency: ☐Constant ☐Intermittent, ____# of hours in pain per day
   Time of Day Pain is at its Worst: ☐ Morning ☐Afternoon ☐Evening ☐Nighttime
   How Often You Stop Activity Due to Pain: ☐Never ☐Rarely ☐Occasionally
   ☐ Several Times a Day ☐Spend Most of the Day Lying/Sitting
5. Activities which relieve pain: _____
6. Activities which increase pain: _____
7. Medications you take to relieve pain (please list all): _____
   _____
8. Current exercise activities: _____

Diagnostic tests performed for this condition:

<u>Test</u>	<u>Date</u>	<u>Location</u>
☐X-Rays	_____	_____
☐CT Scan	_____	_____
☐MRI	_____	_____
☐Bone Scan	_____	_____
☐EMG (nerve test)	_____	_____
☐Other	_____	_____

List the doctors (Primary Care, MD Specialist, Osteopathic Specialist, Chiropractor, or Therapist) you have seen in the last year for your condition:

<u>Doctor's Name</u>	<u>Type of Doctor</u>	<u>Location</u>	<u>Approximate Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Effect of treatment(s) you have had, or are currently receiving, for your pain:

<u>Treatment</u>	<u>Helped</u>	<u>Made Things Worse</u>	<u>No Difference</u>	<u>Currently Receiving</u>
Heat/Ice/Ultrasound	☐	☐	☐	☐
Massage	☐	☐	☐	☐
TENS Unit	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐
Epidural Injections	☐	☐	☐	☐
Back Brace	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐
Mental Healthcare	☐	☐	☐	☐
Chiropractic Care	☐	☐	☐	☐