

GULF COAST ORTHOPAEDICS & PMR

PAIN MANAGEMENT HISTORY AND PHYSICAL FORM

NAME: _____ **DATE:** _____
FIRST MIDDLE LAST

DATE OF BIRTH: _____ **RACE:** _____ **SEX:** Male Female

MARITAL STATUS: Married Single Widowed Divorced Other _____

WHERE IS YOUR PAIN (NECK/BACK)? _____

HOW LONG HAVE YOU HAD PAIN? _____

DESCRIBE what your pain is like:

QUALITY of pain is:

- Constant
- Intermittent
- Throbbing
- Burning
- Aching
- Stabbing
- Sharp
- Shooting
- Other _____

Pain **IS INCREASED** by:

- Sitting
- Standing
- Walking
- Bending
- Lying Down
- Cold
- Heat
- Weather Changes
- Time of Day (AM / PM)
- Other _____

Pain is **DECREASED** by:

- Sitting
- Standing
- Walking
- Bending
- Lying Down
- Cold
- Heat
- Weather Changes
- Time of Day (AM / PM)
- Other _____

ASSOCIATED SYMPTOMS:

- Weakness
- Numbness
- Tingling
- Fever
- Chills
- Muscle Spasms
- Bowel Dysfunction
- Bladder Dysfunction
- Sleep Disturbance
- Other _____

What is the **SEVERITY** of your pain? (Mark an **X** on the appropriate circle below):

(No Pain) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (Extreme Pain)

OCCUPATION: What work do you do? What does your work involve? _____

How many hours per week do you work? _____

How much work, if any, have you missed in the past month due to pain? _____

Do you smoke? No Yes How many packs per day? _____

Do you drink alcoholic beverages? No Yes How much per week? _____

Do you use any **STREET DRUGS**? No Yes (Cocaine, Marijuana, etc.)

CURRENT MEDICATIONS: What, if any, medications are you currently taking?

Please list all current medications below (prescriptions and over-the-counter):

MEDICATION	WHY PRESCRIBED	DOSAGE	EFFECTIVENESS

ALLERGIES: List medications and/or food that you are ALLERGIC to or have had a bad reaction to:

What kind of reaction did you have? _____

Are you taking any anticoagulants (blood thinners)? Yes No If yes, please specify: _____

In the past 6 months to a year, which of the following tests have you had to evaluate your pain?

TEST	DATE	PLACE
<input type="checkbox"/> X-Ray		
<input type="checkbox"/> CT Scan		
<input type="checkbox"/> MRI		
<input type="checkbox"/> EMG		
<input type="checkbox"/> Myelogram		
<input type="checkbox"/> Bone Scan		

PREVIOUS TREATMENTS FOR PAIN: (Please check all that apply):

TREATMENT	HELPFUL?	COMMENTS
<input type="checkbox"/> TENS Unit	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Physical/Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Psychological Evaluations	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Chiropractic Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Nerve Blocks	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SYMPTOM / SYSTEMS REVIEW:

If you have ever experienced any of the following problems, please check the problem and write the year you experienced it right next to the checked item OR check **NO PROBLEMS**.

GENERAL HEALTH / CONSTITUTIONAL SYMPTOMS

- Fatigue
- Night sweats
- Fever/chills
- Difficulty sleeping
- Other _____
- NO PROBLEMS**

HEAD / FACE

- Headaches
- Facial Paralysis
- Masses
- Other _____
- NO PROBLEMS**

EYES

- Blurred or double vision
- Visual disturbances
- Glaucoma
- Cataracts
- Other _____
- NO PROBLEMS**

EARS / NOSE / MOUTH / THROAT

- Earaches or drainage
- Hearing loss
- Ringing in the ears
- Frequent Sore Throat
- Sinus infections/problems
- Difficulty Swallowing
- Voice Change
- Other _____
- NO PROBLEMS**

NECK

- Masses
- Swollen glands in neck
- Thyroid tenderness
- Other _____
- NO PROBLEMS**

CARDIOVASCULAR

- Chest pain or pressure
- Fast or irregular heart beat
- Leg cramps
- Blood clots
- Palpitations
- Swelling of feet and/or ankles
- Swelling of hands
- Poor circulation
- Other _____
- NO PROBLEMS**

RESPIRATORY

- Wheezing
- Chronic or frequent coughs
- Cough with mucous production
- Difficulty breathing
- Shortness of breath when lying flat
- Spitting/coughing up blood
- Shortness of breath when walking
- Other _____
- NO PROBLEMS**

GASTROINTESTINAL

- Heartburn or indigestion
- Rectal bleeding or blood in stool
- Painful bowel movements
- Constipation
- Loss of appetite
- Abdominal pain
- Frequent diarrhea
- Nauseau/Vomiting
- Other _____
- NO PROBLEMS**

GENITOURINARY

- Burning or painful urination
- Blood or pus in urine
- Prostate problems
- Incontinence or dribbling
- Pain with periods
- Sexual difficulty
- Genital rash or ulcers
- Irregular periods
- Change in force of strain
- Prostate problems when urinating
- Other _____
- NO PROBLEMS**

LYMPHATIC / HEMATOLOGIC

- Bleeding or bruising tendency
- Enlarged glands
- Slow to heal after cuts
- Other _____
- NO PROBLEMS**

MUSULOSKELETAL / EXTREMITIES

- Back pain
- Cold extremities
- Other: _____
- Difficulty climbing stairs
- Joint pain
- Difficulty walking
- Joint stiffness or swelling
- Other _____
- NO PROBLEMS**

NEUROLOGICAL / PSYCHIATRIC

- Convulsions or seizures
- Frequent/recurring headaches
- Numbness or tingling sensation
- Tremors
- Anxiety
- Depression / suicidal thoughts
- Memory loss or confusion
- Light headed
- Loss of consciousness
- Dizziness
- Other _____
- NO PROBLEMS**

INTEGUMENTARY / SKIN

- Change in skin color
- Change in hair or nails
- Rash or itching
- Other _____
- NO PROBLEMS**

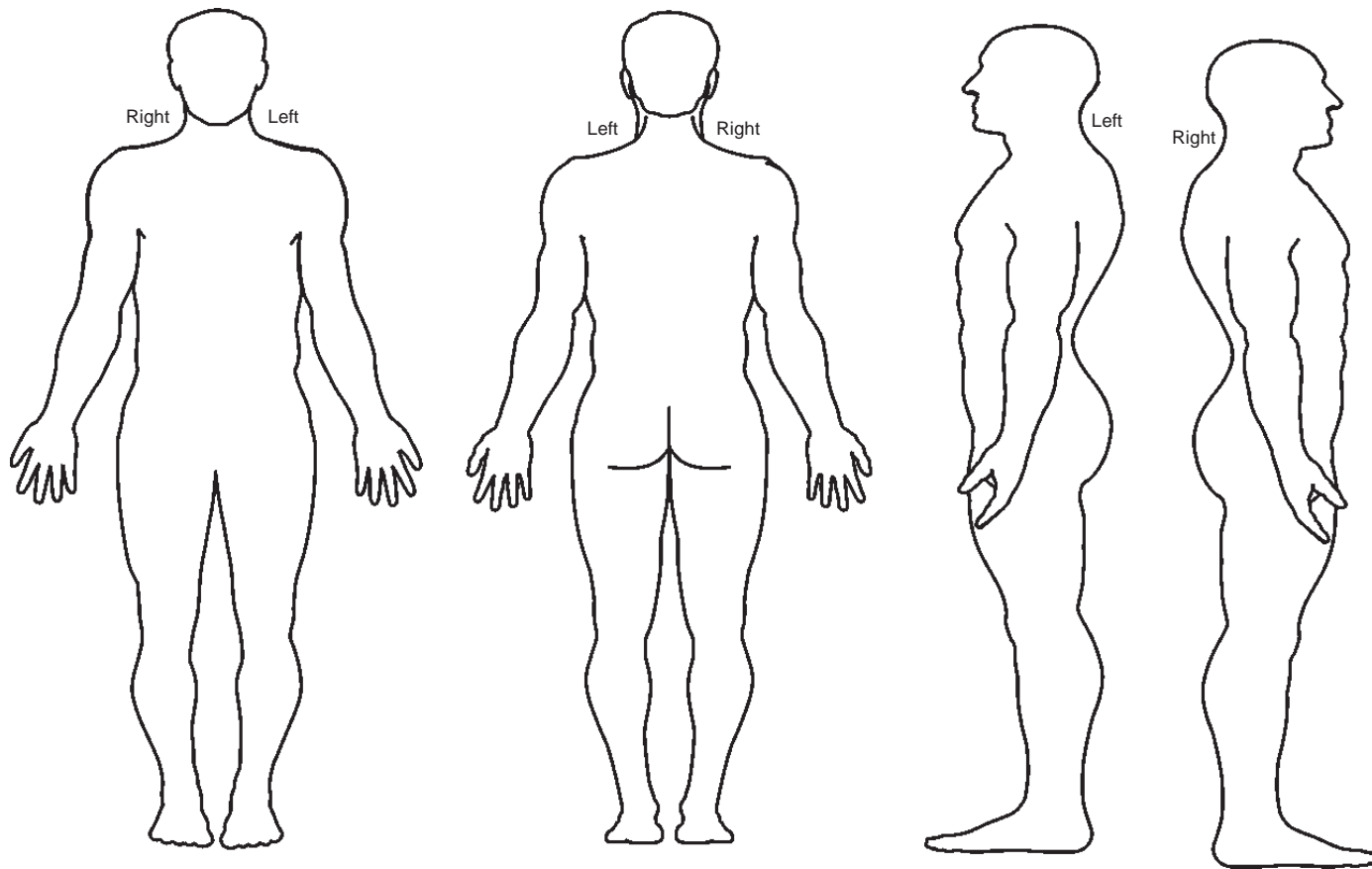
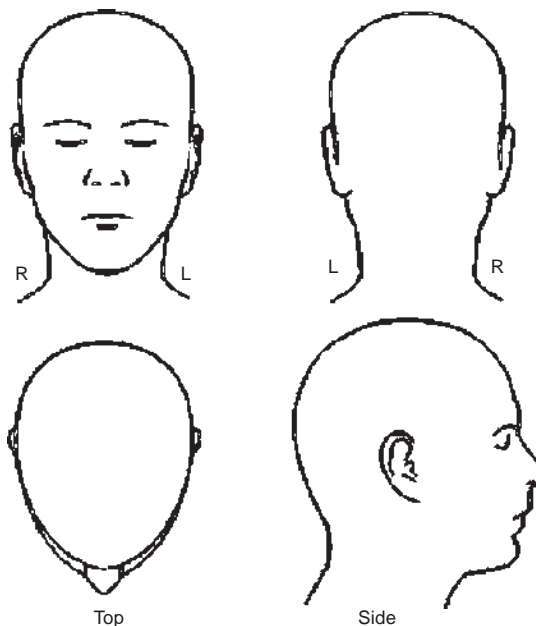
Please use the following symbols to indicate the type and location of your pain on the drawings below.

TYPE OF PAIN	SYMBOL
Sharp	X
Shooting	→
Burning	B
Aching	A
Spasming.....	S
Tingling	T
Numbness	N

EXAMPLE:

Type of pain:
sharp and burning

Location of pain:
back of neck down
to right shoulder blade



Patient's Signature _____