The Pain Intervention Center

Patrick H. Waring, M.D., LLC

Patient Name: _____ Date: _____

Sex: M/F Age: _____ Referring Physician: _____

Address of referring physician: _____

Date of accident/injury: _____

Date of onset of symptoms: _____

1) Chief complaint:

___Neck ___shoulder (R/L) ___Hip (R/L)
___mid back ___elbow (R/L) ___knee (R/L)
___lower back ___wrist/hand (R/L) ___leg/thigh/calf/foot (R/L)

2) history of present illness:

A) type of injury

___no specific injury ___work accident ___slip/fall ___lifting injury
___hit head (loss of Consciousness? Y/N) ___Trip/Fall ___Hit by object
___twisting injury ___Bruising (area:_____)

other: (explain in detail)_____

B) types of treatment since injury:

___no treatment ___tens ___phys. therapy ___chiropractic treatment
___injections ___epidurals ___nerve block
___lumbar brace/corset ___cervical collar ___extremity brace

other treatment:_____

C) are you involved in litigation due to pain? Yes / no

D) Medication taken for Symptoms?

___Anti-Inflammatories ___Pain Medication ___Antidepressants
___ Medication for Sleep ___Anxiety Medication ___Meds for Spasm

list all other medications:_____

E) Did you have surgical treatment for area of today's visit? Yes / no
Type of Surgery: _____

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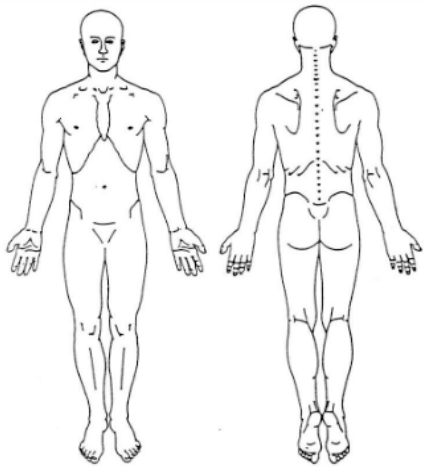
F) **Circle or indicate level of pain:**

Severity: no pain mild moderate severe excruciating

0 1 2 3 4 5 6 7 8 9 10

Use the figures below to mark the areas of present symptoms:

Aching (+++) Numbness (^^^) Pins and needles (000) Burning (- - -) Stabbing (xxx)



Right/Left Left/Right

1) check all that describe your pain:

___Throbbing ___sharp ___cramping ___dull ___comes & Goes
___shooting ___burning ___tingling ___aching ___radiating
___torturing ___Nagging ___Constant

2) identify factors that make your pain **better** (B) or **worse** (W):

___standing ___heat pack ___emotional stress ___sleeping ___stairs
___bending ___walking ___sexual activity ___sitting ___touch ___lying down ___urination ___menstrual cycle ___moving from standing to sitting

Do You Exercise? Yes / No If **No**, Why Not?_____

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3. FAMILY/ SOCIAL/ MEDICAL HISTORY:

A) FAMILY HISTORY: ANY FAMILY HEALTH PROBLEMS (BROTHER, SISTER, PARENTS?)

___NONE ___HIGH BP ___DIABETES ___HEART ATTACK ___HEART DISEASE ___CANCER ___ARTHRITIS ___HIGH CHOLESTEROL ___DEPRESSION ___BACK PROBLEMS ___CHRONIC PAIN

B) SOCIAL HISTORY:

EMPLOYED	___NO	___YES
WORKING	___NO	___YES
DRINK ALCOHOL	___NO	___YES
ILLEGAL DRUG USE	___NO	___YES
SUBSTANCE ABUSE TREATMENT	___NO	___YES
SMOKER	___NO	___YES

TYPE OF WORK (OCCUPATION) : _____

EDUCATION LEVEL : ___HIGH SCHOOL GRADUATE ___GED DIPLOMA
___COLLEGE GRADUATE DEGREE : _____
___DID NOT COMPLETE SCHOOL GRADE LEVEL : _____

C) MEDICAL HISTORY (CIRCLE/CHECK/EXPLAIN)

1. LIST ALL DRUG ALLERGIES _____

2. MEDICAL HEALTH PROBLEMS? (CIRCLE OR CHECK)

___GOOD HEALTH ___HIGH BLOOD PRESSURE ___HIGH CHOLESTEROL
___DIABETES ___KIDNEY DISEASE ___HEART PROBLEMS
___LUNG DISEASE ___MV PROLAPSE ___LIVER PROBLEMS
___STOMACH PROBLEMS ___GLAUCOMA ___BLEED EASILY
___ASTHMA ___ARTHRITIS

3. LIST ALL CURRENT MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER) :
_____

D) SURGICAL HISTORY : (LIST ALL PAST SURGERIES) _____

4. GENERAL REVIEW OF SYMPTOMS: (CIRCLE OR CHECK SYMPTOMS)

A) ANY ILL FEELINGS RECENTLY? YES NO

___GOOD HEALTH ___FEVER ___CHILLS ___FATIGUE
___LOSS OF APPETITE ___LOSS OF ENERGY ___MAJOR WEIGHT LOSS OR GAIN
___DEC. ACTIVITY LEVEL ___NIGHT SWEATS ___UNCONTROLLED SWEATING

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B) Mental Health Problems? Yes/ No
___ no problems ___depression ___disturbed sleep ___suicidal thoughts
___irritability ___anxiety ___nervousness

C) Trouble With Urination? Yes/ No
___frequent urination ___urgency ___trouble stopping/starting
___hesitancy ___nocturia ___burning w/ urination ___loosing control
___erectile dysfunction ___bowel dysfunction ___sexual dysfunction

D) Trouble With Vision? Yes/ No
___blurred vision ___double vision ___vision loss ___eye pain ___use glasses

E) Any Symptoms of Heart Trouble? Yes/ No
___chest pain ___palpitations ___fainting ___shortness of breath
___ankle swelling

F) Any Breathing Problems? Yes/ No
___cough ___wheezing ___shortness of breath

G) Any Stomach Problems? Yes / No
___nausea ___vomiting ___diarrhea ___constipation ___loss of bowel control

H) Muscle or joint problems? Yes/ No
___joint pain ___muscle cramps ___muscle weakness

I) Any Skin Problems? Yes/ No
___rash ___itching ___dryness ___lesions ___open wound/infection
___hair/nail change

J) Any Neurological problems? Yes/ No
___seizures ___numbness ___loss of memory

K) Have you noticed these problems? Yes/ No
___anemic ___cold/heat Intolerance ___abnormal bleeding/bruising

L) Have you experienced these problems? Yes/ No
___enlarged lymph nodes ___hives ___hay fever ___persistent infections

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