Name________________________ Date ______________ Date of birth ____________

Age _________ Sex: M ____ F ____ Height: _____ft. _____ in. Weight _________ lbs

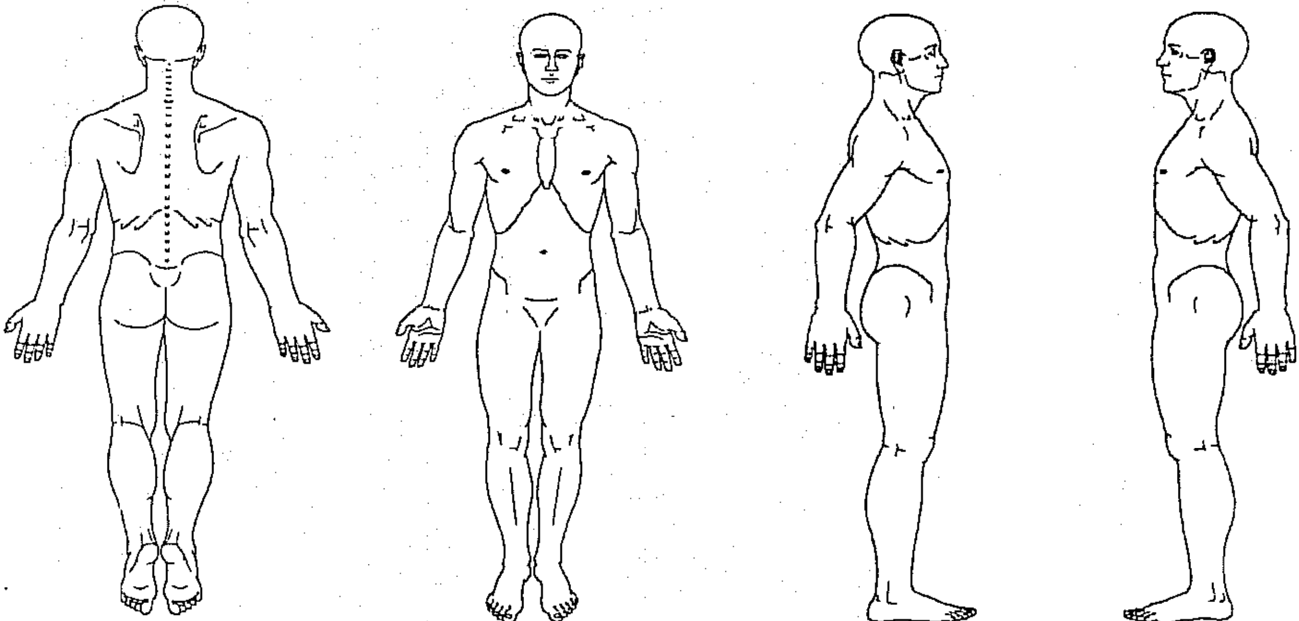
Referring Physician________________________ Primary Physician________________________

List all other physicians involved in your care and their specialty. ________________________

Have you had any of the following?

MRI	Yes_____	No____	Date________	Where________________________
EMG	Yes_____	No____	Date________	Where________________________
CT SCAN	Yes_____	No____	Date________	Where________________________
Myelogram	Yes _____	No____	Date________	Where________________________

Please draw where your pain primarily located? (Please use following diagram.)



***Was the injury work-related?* Yes ____ No _____** ***Are you involved in a lawsuit?* Yes ____ No _____**

When did the pain begin? ________________________

Did it begin gradually or suddenly? ❑ Gradually ❑ Suddenly

If suddenly, is it the result of an injury? ❑ Yes ❑ No

If so, please describe the injury.________________________

Is it getting worse or has it improved? ❑ Improving ❑ Worsening

Please describe your pain in as much detail as possible.________________________

____

INITIAL PATIENT HISTORY/ASSESSMENT FORM

PainCARE
10501 Metcalf Ave.
Overland Park, KS 66212

S:\Patient Forms\initial assessment form revised 09/09.doc

Please mark your average (A) pain and your maximum (M) pain on the line below:

0 1 2 3 4 5 6 7 8 9 10

No Pain____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____ Worst Pain Imaginable

Do you have any other symptoms such as numbness, weakness, or pins and needles sensations? Please describe.

____

- Do you have new onset of bowel or bladder problems related to this? ☐YES ☐No

What makes your pain worse? Standing________Sitting________Walking_______Lying Down_______

Does the pain affect your sleeping? Yes ____ No____ If so, how? ______________________________________

____

What have you found that makes your pain better?____

What is your occupation? ____

Does the pain interfere with your ability to work? Yes ____ No ____

If so, how? ____

Please circle any of the following activities of daily living that you have had difficulty doing because of your pain:

Using the toilet Dressing Bathing Eating Getting up from a bed or chair

If you have experienced **NO** difficulty with the above activities of daily living please check this box: ☐

Do you need any assistance walking? Yes ____ No_____ If so, what type?____________________

Please list any previous treatments for your pain:

Treatment	Please Circle Yes or No	Treatment Duration	Improved	No Change	Worse
Physical Therapy	Yes/No				
Chiropractor	Yes/No				
Injections/Blocks	Yes/No				
Exercise	Yes/No				
TENS/Electrical Stimulation	Yes/No				
Traction	Yes/No				
Bed Rest/Rest	Yes/No				
Back Support	Yes/No				
Manipulation	Yes/No				

Please list any Medications you have tried for pain relief (including Tylenol, Advil, and/or Prescription Drugs):

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Do you have any allergies to any medications, latex, iodine, contrast dye, or tape? Yes_____ No ______

Please list below the item/medication and reaction below:

Item/Drug	Reaction	Item/Drug	Reaction

ARE YOU TAKING ANY BLOOD-THINNING MEDICATIONS? (e.g. ASPIRIN, COUMADIN, TICLID, PLAVIX)

YES________ NO__________

Please list any medications you are currently taking. Include vitamins, over-the-counter medications, herbal preparations, laxatives, or inhalers.

Medication & Dose	How often	Medication & Dose	How often
1)		9)	
2)		10)	
3)		11)	
4)		12)	
5)		13)	
6)		14)	
7)		15)	
8)		16)	

Review of Systems:

Do you have or have you had any of the following conditions?

__Fever, chills, night sweats
__Weight gain or loss
__Fatigue, lack of energy
__Glaucoma, cataracts
__Headaches
__Deafness, ringing in ears
__Sinus problems
__Nosebleeds
__Chest Pain
__Palpitations
__Irregular heartbeat
__Swelling ankles, hands
__Shortness of breath
__Wheezing or cough
__Heartburn
__Pain in stomach
__Nausea, vomiting
__Poor appetite
__Diarrhea
__Constipation
__Pain with urination
__Skin rash or itching
__Joint pain, swelling, stiffness
__Hard of hearing
__Tremor, seizures, or blackouts
__Depression or anxiety
__Heat or cold intolerance
__Unusual bleeding or bruising
__Glasses

___All others Negative

Comments: (Explain anything marked above, if necessary.)______________________________________

____

Please mark any health problem you have had in the past

__Heart Disease
__Congestive Heart Failure
__High Blood Pressure
__Stroke/TIA
__Infectious Conditions, i.e. Hepatitis
__Cancer, Type ______________________________
__Kidney Disease
__Kidney Infections
__Heart Failure
__Hypo/Hyper Thyroid
__Diabetes
__Mental Disorder
__Liver Disease
__Bronchitis
__Gastritis
__Neuropathy
__Depression
__Circulation Problems
__Asthma
__Ulcers
__Migraines
__Glaucoma

Please list any surgeries you have had

Date: ______________ Surgery: ____

Date: ______________ Surgery: ____

Date: ______________ Surgery: ____

Date: ______________ Surgery: ____

Date: ______________ Surgery: ____

Is there any possibility you could be pregnant? Yes ____ No ____

Health History:

	Age (Living)	Age (At Death)	State of Health/Illnesses/Cause of Death
Father			
Mother			
Siblings:			

Tobacco Use: Packs/Day_____ Number of Years______ (Currently) Packs/Day_____ Number of Years______ (Previously)

If you have quit smoking, how long ago? __________________

Alcohol Use______________ Amount per Week

Form completed by:

________________________________ ________________________________ M.D.____________Date

________________________________ R.N. ____________Date

Name of who will drive you home today

____

Form reviewed: ________________________________ M.D.____________Date

________________________________ R.N. ____________Date