



Patient Name: _____ Provider: _____

Date of Birth: _____ Date: _____

Pain Management History Form

Age: ____ Sex: F M Dominant Hand: R L Height: _____ Weight: _____ (ORA staff to fill out: P _____ R _____)

Primary Care Doctor's Name: _____

List any other doctors and their specialty that you see: _____

Who requested that you be seen here? Primary care provider Emergency room or urgent care provider yourself other

Your hospital preference? _____

What problem are you being seen for today? R L _____

When did your problem start or what was the date of the injury? _____

What tests/treatments have you had for this problem? X-Rays MRI CT scan Bone scan Ultrasound

Nerve Test (EMG/NCV) When? _____ Where? _____

TREATMENT	WHEN? HOW OFTEN?	WHERE?	WAS IT HELPFUL?
PHYSICAL THERAPY			
CHIROPRACTIC			
BRACE			
TENS UNIT			
EPIDURAL STEROID INJECTION			
MEDICATIONS			
RADIOFREQUENCY ABLATION			
SPINAL CORD STIMULATION			
TRIGGER POINT INJECTION			

Since my problem started, it is: Getting better Getting worse Unchanged

Has your problem kept you from: Working Recreational activities Activities of daily living like cleaning & dressing yourself

I experience: Pain Bruising Numbness Tingling Weakness Loss of control bowel/bladder
 Locking Catching Instability Swelling Stiffness Other _____

If you have pain: How would you describe the type of pain? Sharp Dull Stabbing Throbbing Aching Burning

On a scale of 0 - 10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

The pain is: Constant Intermittent (comes & goes)

Does the pain radiate/travel/move? Y N If yes, where _____

Does your pain wake you from sleep? Y N

What makes your symptoms worse? Walking Stairs Exercising Twisting Kneeling Direct pressure
 Standing Sitting Lying flat Bending Lifting Coughing / sneezing

What makes your symptoms better? Rest or not moving Sitting Lying Standing Exercise / movement Elevation
 Ice Heat Compression or bracing Injections Pain pills Other medications

If there was a specific injury (including work related injuries), please describe what happened:

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REVIEW OF SYSTEMS

Have you recently had any of these symptoms? Please check all that apply. If none of the below apply, then mark NONE.

- | | | | | |
|---|---|--|--|---|
| Skin
<input type="checkbox"/> Frequent Rashes
<input type="checkbox"/> Open Wounds
<input type="checkbox"/> Itchy/Red | ENT
<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Difficulty Swallowing | Neuro
<input type="checkbox"/> Headaches
<input type="checkbox"/> Numbness
<input type="checkbox"/> Weakness
<input type="checkbox"/> Frequent Falls | Kidney/Bladder
<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Urinary Infections | Cardio
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Irregular Beat
<input type="checkbox"/> Calf Pain
<input type="checkbox"/> Swelling Feet/Ankle |
| Eye
<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Vision Loss
<input type="checkbox"/> Double Vision | Digestive
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Blood in Stool | Glands
<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Always Hot/cold
<input type="checkbox"/> Lymphedema | Bones/Joints
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Joint Problems
<input type="checkbox"/> Broken Bones | Psych
<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety |
| Lung
<input type="checkbox"/> Short of Breath
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Chronic Cough | Blood
<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Easy Bleeding | Const
<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Frequent Fever
<input type="checkbox"/> Loss of Appetite | | |

PAST MEDICAL HISTORY

Do you have a history of any of the following: (Please check all that apply)

- | | | | | |
|---|--|---|--|---|
| Bones/Joints
<input type="checkbox"/> Broken
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Arthritis | Circulation
<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Clotting Disorders
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Stroke
<input type="checkbox"/> Elevated Cholesterol | Lung
<input type="checkbox"/> Asthma
<input type="checkbox"/> COPD
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Sleep Apnea | Kidney
<input type="checkbox"/> Infection
<input type="checkbox"/> Stones | Digestive
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Reflux
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Dialysis |
| Heart
<input type="checkbox"/> Open Heart
<input type="checkbox"/> Stents
<input type="checkbox"/> Heart attack
<input type="checkbox"/> Pacemaker | Current/Past Infection
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
<input type="checkbox"/> HIV/Aids
<input type="checkbox"/> MRSA
<input type="checkbox"/> VRE | Glands
<input type="checkbox"/> Diabetes Type I
<input type="checkbox"/> Diabetes Type II
<input type="checkbox"/> Thyroid | Neuro
<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Seizures | Other
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Cancer
<input type="checkbox"/> _____ |

List all past surgeries and what year that they occurred: NONE Appendectomy Tonsil Adenoids C-section/s Bypass
 Gall bladder Tubes in ear Hernia repair Oral surgery Hysterectomy Tubal ligation Orthopedic surgery (please list below)
 Others: _____

FAMILY HISTORY

Adopted and family medical history is not known No significant medical history of any direct relatives

List any major medical problems (examples: diabetes, heart disease, cancer, arthritis ...) of your direct relatives:

Mother: _____ Father: _____
 Grandparents: _____
 Brothers/Sisters: _____ Children: _____

SOCIAL HISTORY

Do you use tobacco? No Quit Yes - How much? _____ Alcohol use? No Yes - How much? _____

History of substance abuse? No Yes

Student at _____ What grade level _____ Participating in what sports? _____

Are you currently working? Y N Type of job: _____ Disabled Retired

Marital Status: Single Married Widowed Children: Y N Are you pregnant? Y N Unknown



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Are you allergic to any medications? Y N If yes, please list below and list the reaction (hives/stopped breathing/rash/swelling):

Other Allergies: Latex Food Seasonal Metal Other Have you ever had a reaction to anesthesia? Y N _____

Current Medications, the dose and frequency (list all prescription and over the counter medications/supplements):

Mark the areas on your body where you feel pain using the following symbols:

Aching

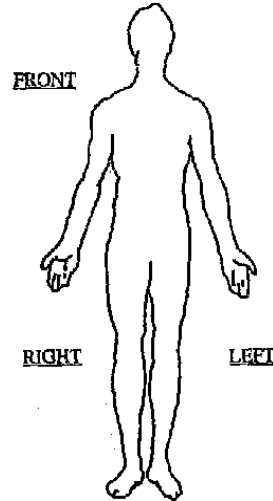
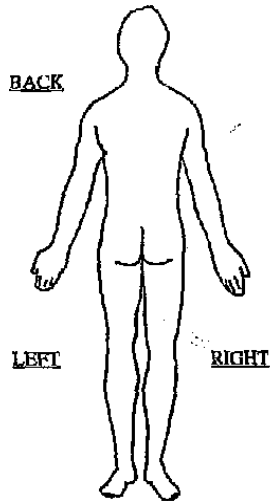
Numbness

Tingling

Pins and Needles

Burning

Stabbing



Patient Signature

The information on this form is accurate to the best of my knowledge.

Date

FOR OFFICE USE ONLY: (Initial and date when completed and with each update)

Review#1 by:

Date

Review #2 by:

Date