

History of present illness form

Name: _____ Date: _____ PCP: _____ DOB: _____

Referring Physician: _____ Ht: _____ Wt: _____

Please fill out the following form to help us learn more about your condition so that we can better assist your needs.

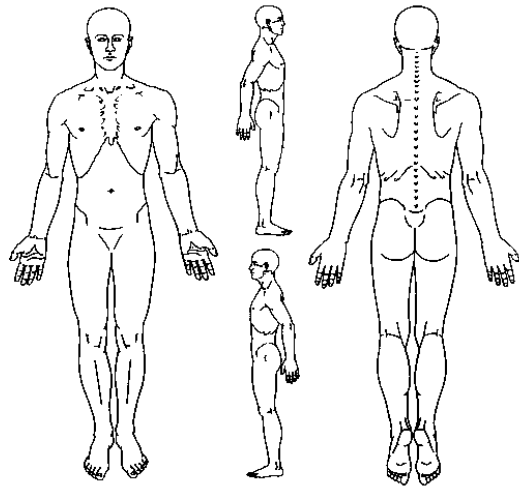
1. When did your pain begin?

What caused your pain to begin?

Was your injury work related?
If so, what date?

Have you pursued legal action for
an injury?

Who diagnosed the problem?



2. Where is your worst pain located?

3. Circle any of these to describe your pain quality:

Aching Burning Gnawing Sharp Shooting Spasm

Other: _____

4. **Severity** of pain scale

Please circle your answer below

0 is no pain and 10 is the worst pain

0 1 2 3 4 5 6 7 8 9 10

Does pain affect your sleep?

Yes

No

How does the pain affect your activity?

Mild: does not interfere with daily activities

Moderate: interferes with some daily activities

Severe: interferes with most, but not all, daily activities

Very severe: unable to carry out any daily activities

5. **(Timing)** When you have pain, how long does it last?

Is it "constant" _____ or "come and go" _____

6. Circle the correct answer:
When is your pain best? AM Afternoon Night
When is your pain worst? AM Afternoon Night

7. Circle what **aggravates** or makes your pain worse:
Sitting Standing Walking Bending Lying Down
Other: _____

8. Circle what **relieves** or makes your pain better:
Sitting Standing Walking Bending Lying Down
Other: _____

9. Is your pain **associated** with the following?
Weakness? _____ Where? _____
Numbness? _____ Where? _____
Tingling? _____ Where? _____
Skin color or temperature change? _____ Where? _____
Bowel or bladder problems? _____ How? _____
Skin sensitive to touch? _____ Where? _____
Skin sensitive to heat or cold? _____ Where? _____

10. What **tests** have you had done?
X-Rays: _____ Date: _____ Results: _____
MRI: _____ Date: _____ Results: _____
Catscan: _____ Date: _____ Results: _____
Myleogram: _____ Date: _____ Results: _____
EMG/NCS: _____ Date: _____ Results: _____

Treatments/Surgeries

11. Circle any **previous treatments** you have tried. List how they helped.
Doctors: _____
Pain specialists: _____
Epidurals/Injections: _____
Physical therapy: _____
Chiropractor: _____
Ice/Heat: _____
TENS unit: _____
Massage: _____
Over the counter medications: _____
Prescription medications: _____

Medications

12. List all the medications you are **currently** prescribed for pain, **and all other** prescription and non-prescription medications you also take:

Allergies and blood thinners

13. Are you taking any blood thinners? _____
List any medications you are allergic to: _____

Previous Surgeries

14. Previous surgeries and year performed: No surgeries

Neck surgery: _____ Gallbladder: _____ Broken bones: _____
Back surgery: _____ Heart surgery: _____ Chest/lung surgery: _____
Hysterectomy: _____ Stomach/hernia: _____ Appendectomy: _____

List any additional surgeries: _____

Past medical history

15. Are you currently, or have you in the past, been treated for any medical conditions? Please explain: _____

Social history

16. Most recent occupation: _____

Circle the correct answer:

Current employment status: Full time Part time Retired Disabled

Marital status: Single Married Divorced Legally Separated Widowed

Children living at home? Yes No **Ages:** _____ **Do you live alone?** Yes No