

Rehabilitation Medicine Associates, PC

PAIN HISTORY

Please be sure to bring any recent X-rays to your appointment. Please take a few minutes before your visit to complete this form.

Name: Last First MI Age Date of Birth

Describe your current symptoms/pain:

Blank lines for describing symptoms/pain.

When did your pain start?

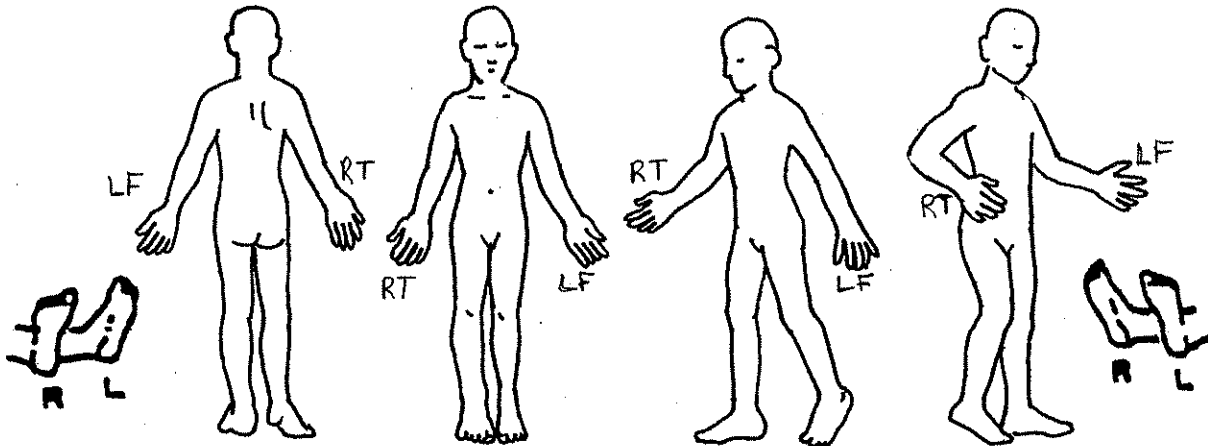
How/why did your pain start? (Do not repeat this section if you are an injured worker.)

Blank lines for describing how/why pain started.

PAIN DESCRIPTION

[PAIN DIAGRAM]

Mark the affected areas on your body where you now feel your typical pain. Put a star by your worst pain.



Pain Severity

If 0 is no pain, and 10 is the worst pain imaginable, please note your pain over the last two weeks:

- a) Please rate your Worst pain. 0 1 2 3 4 5 6 7 8 9 10
b) Please rate your Least pain. 0 1 2 3 4 5 6 7 8 9 10
c) Please rate your Average pain. 0 1 2 3 4 5 6 7 8 9 10

How would you describe your overall severity of pain?

- Mild nuisance pain Moderate: I am having difficulty dealing with it
Mild to moderate but I can live with it Severe: it is ruining my quality of life

How would you describe the kind of pain you have? (Check all that apply.)

- Sharp Burning Other
Stabbing Pins and Needles
Aching Cramping
Dull Throbbing

Do you have associated symptoms?

- Numbness (If yes, where?)
Weakness (If yes, where?)

TREATMENT

List the doctors, chiropractors, osteopaths, etc., you have seen in the last year for your pain.

TYPE OF DOCTOR DOCTOR'S NAME LOCATION APPROXIMATE DATES

EFFECT OF TREATMENT

Put a check next to each type of treatment you have had for your pain in the past. Then check the column that best describes the effect of the treatment. If you have had treatments not given on the list, write them in at the bottom and indicate how they affected you.

| TREATMENT | Helped | Made things worse | Didn't do much either way |
|--------------------------|--------|-------------------|---------------------------|
| Hot packs/ice/ultrasound | _____ | _____ | _____ |
| Massage | _____ | _____ | _____ |
| Electrical stimulation | _____ | _____ | _____ |
| TENS unit for home use | _____ | _____ | _____ |
| Body mechanics training | _____ | _____ | _____ |
| Epidural injections | _____ | _____ | _____ |
| Soft back brace | _____ | _____ | _____ |
| Rigid back brace | _____ | _____ | _____ |
| Acupuncture | _____ | _____ | _____ |
| Other _____ | _____ | _____ | _____ |

Are you currently receiving any treatments listed above? Yes No

If yes, which ones? _____

If you are not under active treatment as listed above, approximately how long has it been since you have been under treatment for your pain? _____

Do you have a home exercise program that you do on a regular basis? Yes No

Have you received care from a mental health professional? Yes No

If yes, briefly explain: _____

SURGERIES (for this pain/condition)

| Date | Type of Surgery |
|-------|-----------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |