

Please take a few minutes to complete this worksheet
This information will help us to provide better care.

Name: _____
Height: _____ Weight: _____

Medical History:

Have you ever had or been told you have (Check all that apply)?

Cardiovascular:

- Chest Pain or Angina
- Heart Disease
- MI, Heart Attack, Blocked artery
- Congestive heart failure
- High Blood Pressure
- Peripheral vascular disease
- Abnormal heart beat
- Pacemaker
- Angioplasty or heart Cath
- Rheumatic fever
- Damaged heart valve

Respiratory:

- Asthma
- Shortness of Breath
- Emphysema
- TB

Metabolic:

- Diabetes
- Thyroid disease
- Adrenal gland problem
- Steroid use

Neurological:

- Multiple sclerosis
- Seizures/Fainting spells/dizziness
- Stroke
- Headaches / Migraines
- ALS

Liver/Kidney/Blood:

- Kidney disease
- Anemia
- Dialysis
- Liver disease

Gastrointestinal:

- Ulcers, heartburn, reflux
- Diverticulitis or Colitis

- Gallbladder
- Hepatitis (Type ____)
- Dysphagia

Other:

- Easy Bruising or bleeding
- Anticoagulants (Blood Thinners)
- Depression or Anxiety
- Arthritis, Rheumatism
- Cancer _____
- Other: _____
- Fibromyalgia
- Lupus
- HIV/AIDS
- Osteopenia/osteoporosis
- Chronic pain
- Falls

Do you currently use a:

- Cane
- Walker
- Wheelchair
- Hearing aid
- Glasses

Social History

- Alcohol _____ Drinks per day
- Smoking _____ Packs per day
- Other drug use (e.g. Cannabis, IV drugs...) _____

Family History:

- Maternal _____
- Paternal _____

Employment Status:

- Employed Full time
- Employed Part Time
- Self Employed
- Unemployed for other reasons
- Retired
- Unemployed due to pain
- Disability

Occupation: _____

Allergies:

Reaction:

All medications you take at home:

Medication: _____ Dose: _____ How often: _____

Previous Surgeries (Please include date)

ROS: Please circle if you are currently having any of the following:

- Fever, Chills, night sweats, Weight loss, malaise,
- Cough, shortness of breath, wheeze
- Weakness or paralysis of arms and legs
- Headaches How often? _____
- Dizziness, vision change, lightheadedness
- Swelling or Rash _____
- Abdominal Pain, Nausea/vomiting
- Change in bowel habits, bowel/bladder control loss
- Chest Pain, Palpitations
- Pregnant or possibly pregnant?
- Other: _____



Where is most of your pain? _____

Does it go anywhere else? Yes or No
If yes so where? _____

When did your pain start? _____

How long have you had this pain? _____
Did it start Gradually Suddenly Not sure

How often do you experience this pain?
_____ Constant _____ Comes and Goes

Is your pain getting _____ Better _____ Worse
_____ Staying the same

Have you had any X-Rays or MRIs done? Yes or No
If yes so, when, and where? _____

Check what most describes your plan?

- Aching
- Cramping/spasm
- Dull
- Hot/Burning
- Numbing
- Pins/Needles
- Pressure
- Sharp
- Shooting
- Stabbing
- Throbbing
- Tingling

Rate your pain at its worst:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Rate your pain at its best:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Rate your pain on average:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Rate your pain at the moment:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

What makes your pain worse?

- Bending
- Changing Position
- Defecation
- Going up stairs
- Heat
- Going down stairs
- Increased Activity
- Lying Flat
- Lifting
- Movement
- Sitting long time
- Sneezing
- Standing long
- Standing straight
- Turning to the left
- Turning to the right
- Turning side to side
- Walking

What Makes your pain better?

- Assistive devices
- Changing Position
- Cold
- Exercise
- Heat
- Injections
- Massage
- Lying Flat
- Manipulation
- Medication
- Physical Therapy
- Rest
- Sitting
- Standing
- Walking

What treatments have you tried?

- Exercise
- Massage
- Chiropractic
- Acupuncture
- Brace
- Physical Therapy
- Heat
- Ice
- Nerve Block
- Biofeedback
- TENS Unit
- Traction
- Psychologist
- Surgery

What medications have you tried (Circle)

- NSAIDs:** Aspirin, Ibuprofen, Advil, Motrin
- Relaxants:** Flexeril, Valium, Xanax, Ativan
- Sleep Medicines:** Ambien, Benadryl
- Antidepressants:** Cymbalta, Amitriptyline
- Narcotics:** Tramadol, Vicodin, Codeine, Percocet, MS Contin, Demerol, Morphine, Dilaudid, Methadone.
- Neuropathic Medication:** Gabapentin, Lyrica
- Other** _____

On the diagram, please shade in the areas where you have pain?

