NORTHSHORE INTERVENTIONAL PAIN MANAGEMENT CENTER

PAIN HISTORY

Where is your pain? _____
(For a complete description, please fill in pictures and adjectives on the last three pages)

When did you first notice your pain? Month _____ Day ____ Year_____
Under what circumstances did your pain begin? (Check One and Give Date)

___ Accident at Work Date of Injury _____

___ Accident at Home Date of Injury _____

___ At Work, but not an Accident Date of Injury _____

___ Pain just began, No reason

___ Motor Vehicle Accident Date of Accident _____

___ Following Surgery Date of Surgery _____

___ Following Illness Date of Illness _____

___ Other (Describe) _____

_____

_____

Since your pain began, has it: (Check One)
( ) Increased ( ) Decreased ( ) Stayed the same

What is your Height _____? What is your Weight _____?

Occupation: _____ How long in this position? _____
Brief description of your usual job duties?

_____

Work Status: (Please check one of the following)
Full Time ___ Part Time ___ Student ___ Disabled ____ Unemployed ____
Retired ___
If disabled (as worker, student, homemaker) date last worked: _____
If working less than full time, is pain the reason? ____Yes ____ No
If disabled, have you tried to return to work? ___ Full Time ____ Part Time ___ No
Did your employer allow you to return? ____ Yes ____ No
Do you think you can work your regular job? ___ Yes ___ No
If you had no pain, would you plan to go back to work? ___ Yes ___ No
Compared to your ability before your illness/injury you can now do:
___ As much as before__ Somewhat less than before __ Much less than before __ Cannot at all

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PAIN HISTORY

Previous treatments for your pain Yes No
(Please check one and specify name of facility or doctor)

_____
Traction

_____
TENS Unit

_____
Occupational/ Physical Therapy

_____
Biofeedback

_____
Hypnosis

_____
Counseling (Psychotherapy)

_____
Chiropractor

_____
Acupuncture

_____
Osteopathic Treatment

_____
Heat Therapy

_____

Do you take prescribed medication? (Check One) _____ Yes ___ No
Please list all medication name, dosage, and how many times per day:

_____

_____

_____

Are you taking any over the counter medications that your doctor did not prescribe? (aspirin/ibuprofen or other)? (Check One) ___ Yes ___ No
If yes, please list: _____

_____

Name of Pharmacy used and phone number _____

FAMILY HISTORY

___ Cancer (any type) __ Cardiac Disease __ Arthritis ___ Diabetes
___ Alcoholism __ Drug Abuse __ Psychiatric Disorder

NORTHSHORE INTERVENTIONAL PAIN MANGEMENT CENTER

PAIN HISTORY

Allergies?
Please list any allergies you have (including medication and foods) :

_____

_____

Have you had any of the following conditions? (Please circle and describe information in both columns)

Yes No Cardiac problems
Yes No Pacemaker
Yes No High Blood Pressure
Yes No CVA (Stroke)
Yes No Dizziness
Yes No Arthrtis
Yes No Anemia
Yes No Previous Blood Transfusion
Yes No Measles
Yes No Mumps
Yes No Chicken pox
Yes No ENT Problems
Yes No Cataracts
Yes No Are you pregnant?
Yes No Are you trying to get pregnant?

Yes No Thyroid disorder
Yes No Hepatitis, jaundice,liver disease
Yes No Asthma
Yes No Tuberculosis
Yes No Other Pulmonary disease
Yes No Cancer
Yes No GU/bladder/prostate problems
Yes No Rheumatic Fever
Yes No Glaucoma
Yes No Kidney disease
Yes No Skin Disorder/Rash
Yes No Transplant
Yes No Mitral Valve Prolapse
Last menstrual period_____

Yes No Do you smoke/ use tobacco products-now or in past?
Type: _____ Amount:_____ How many years:_____
Yes No Are you taking any anticoagulants (blood thinner) ?
Yes No Bleeding problems
Yes No Do you drink?
Type/amount: _____
Yes No Anesthesia problems

Yes No Sexually transmitted disease
Yes No Immunizations up to date?
Yes No Communicable disease exposure
Yes No Psychiatric / mental disorder
Yes No Sickle Cell disease/ trait

Level of Education:_____
Yes No Dentures/ partial/ other
Yes No Visual problems/ glasses

Yes No Seizures
Yes No Diabetes
Yes No Drug Dependence

Yes No Coffee/Caffeine drink Use. Amount/day :_____
Does your pain interrupt your sleep? (Check One) _____ Yes _____No
How many times a night?_____ Do you take medication to help you sleep? _____
What makes your pain worse?_____
_____
What makes your pain better?_____
Have you had any recent changes in your appetite or weight? (Please circle either that applies)

REVIEW OF SYSTEMS - INITIAL EVALUATION

✓ ***Check any that apply to you:***

Constitutional: ____ fever ____ unexplained weight change ____ flu like symptoms
____ recent trips out of the United States

Ear, nose, throat & mouth: ____ headaches ____ vision changes
____ hearing loss ____ ringing in your ears ____ dizziness
____ runny nose ____ hoarseness ____ oral tissue lesions

Cardiovascular: ____ chest pain ____ heart attack ____ falling out episodes
____ acute congestive heart failure past six months

Respiratory: ____ wheezing ____ S.O.B. ____ asthma
____ environmental allergies ____ smoking

Gastrointestinal: ____ difficulty swallowing ____ indigestion ____ abdominal pain
____ nausea ____ vomiting ____ diarrhea
____ constipation ____ jaundice ____ change in bowel function
____ rectal bleeding ____ inability to control bowel movements

Genitourinary: ____ painful urination ____ frequent urination
____ blood in urine ____ unable to control urination
____ nocturia (need to urinate at night)
____ last menstrual period

Musculoskeletal: ____joint swelling ____ restriction ____ muscle pain ____joint pain

Integumentary (skin and/or breast): ____ rashes ____ lesions
____ change in hair or nails ____ open skin sores, lacerations or abrasions

Neurological: ____ seizures ____ fainting spells ____ paralysis
____ tremor ____ weakness

Psychiatric: ____ depression ____ suicide attempts/plans ____ anxiety disorders
____ fear of needles

Endocrine: ____ diabetes ____ thyroid disorders

Hematologic / Lymphatic: ____ anemia ____ abnormal bleeding
____ excessive bruising ____ swollen glands
____ previous blood transfusions ____ pitting edema

Social History:
Marital Status: ___ Married ___ Single ___ Divorced/Separated ___ Widowed

Current Employment: ___ Working / Occupation _____; ___ Unemployed ___ Retired

Military Service: ___ Yes ___ No If yes, branch _____

Use of "Street / Non-Prescription" drugs: ___ Yes ___ No Explain: _____

Alcohol Use: ___ None ___ Other Explain: _____

Level of Education: _____ Sexual History: _____ / ___ Prefer Not to Answer

Patient Signature _____ Date _____

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PAIN HISTORY

Have your had any of these tests?

TEST	DATE	LOCATION
X-Ray		
Laboratory/Blood		
CT Scan/MRI		
EMG (Nerve Conduction)		
Myelogram		
Thermogram		
Epiduralgram		
Other		

Who referred you to the Pain Center? _____
Other physicians you are currently seeing _____

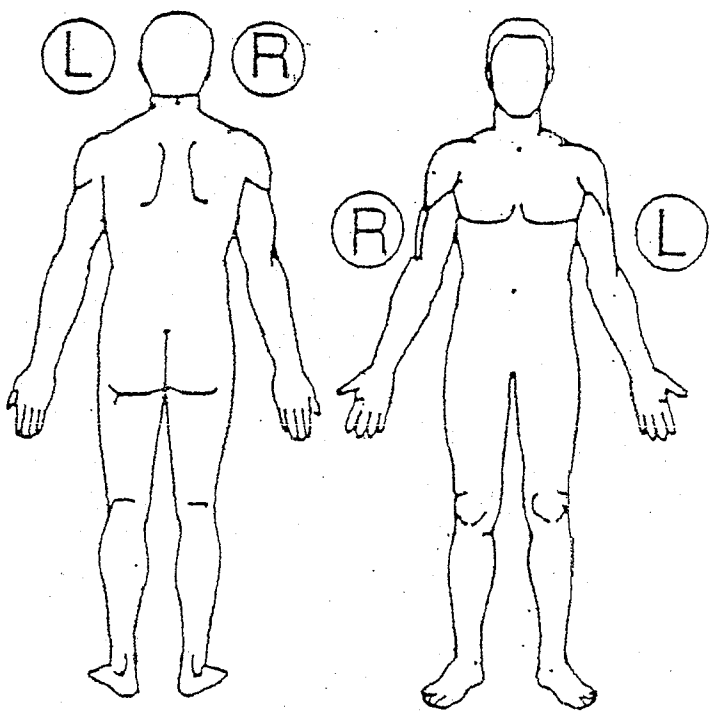
Please list any surgeries you have had and the approximate dates:_____

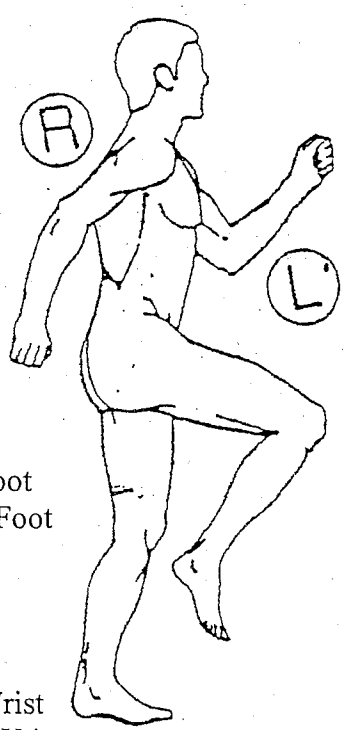
During your care at Northshore Interventional Pain Management Center, we periodically call your home to inform you of upcoming appointments, outcome of treatment, etc. Do you object to us leaving a message for you on your answering machine? (Circle One) Yes/No
Do you have certain persons that you would **NOT** like us to discuss your condition with when we call your home? If so, please list:_____
Would you prefer we call you at work if you do not answer at home? (Circle One) Yes/ No
If yes, please list work number:_____

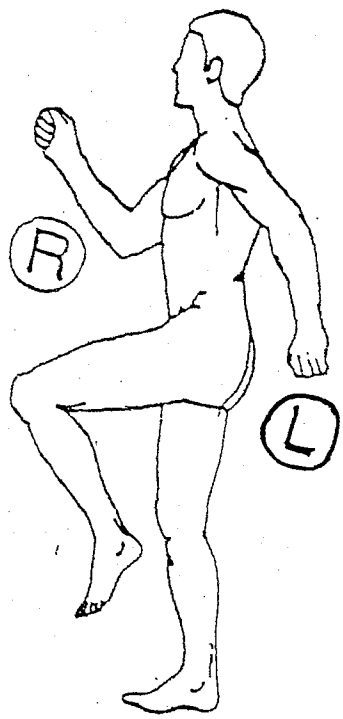
NORTHSHORE INTERVENTIONAL PAIN MANAGEMENT CENTER

PAIN HISTORY

On the drawings below, please indicate exactly where your pain is located. If the pain begins in one spot and travels to another, then draw a line to where it ends. If it involves a whole area, then shade in the affected area. If your pain is in the head or face areas, please use next page.



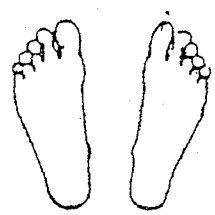


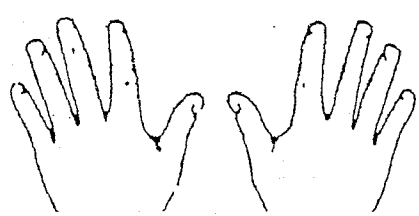


Where is your pain located? Check Areas.

___ Low Back
___ Mid Back
___ Upper Back
___ Neck
___ Chest
___ Abdomen
___ Groin
___ Left Buttock
___ Right Buttock
___ Left Thigh
___ Right Thigh
___ Left Calf
___ Right Calf
___ Left Ankle or Foot
___ Right Ankle or Foot
___ Left Shoulder
___ Right Shoulder
___ Left Arm
___ Right Arm
___ Left Hand or Wrist
___ Right Hand or Wrist
___ Head
___ Face
___ Other (List)

_____
_____





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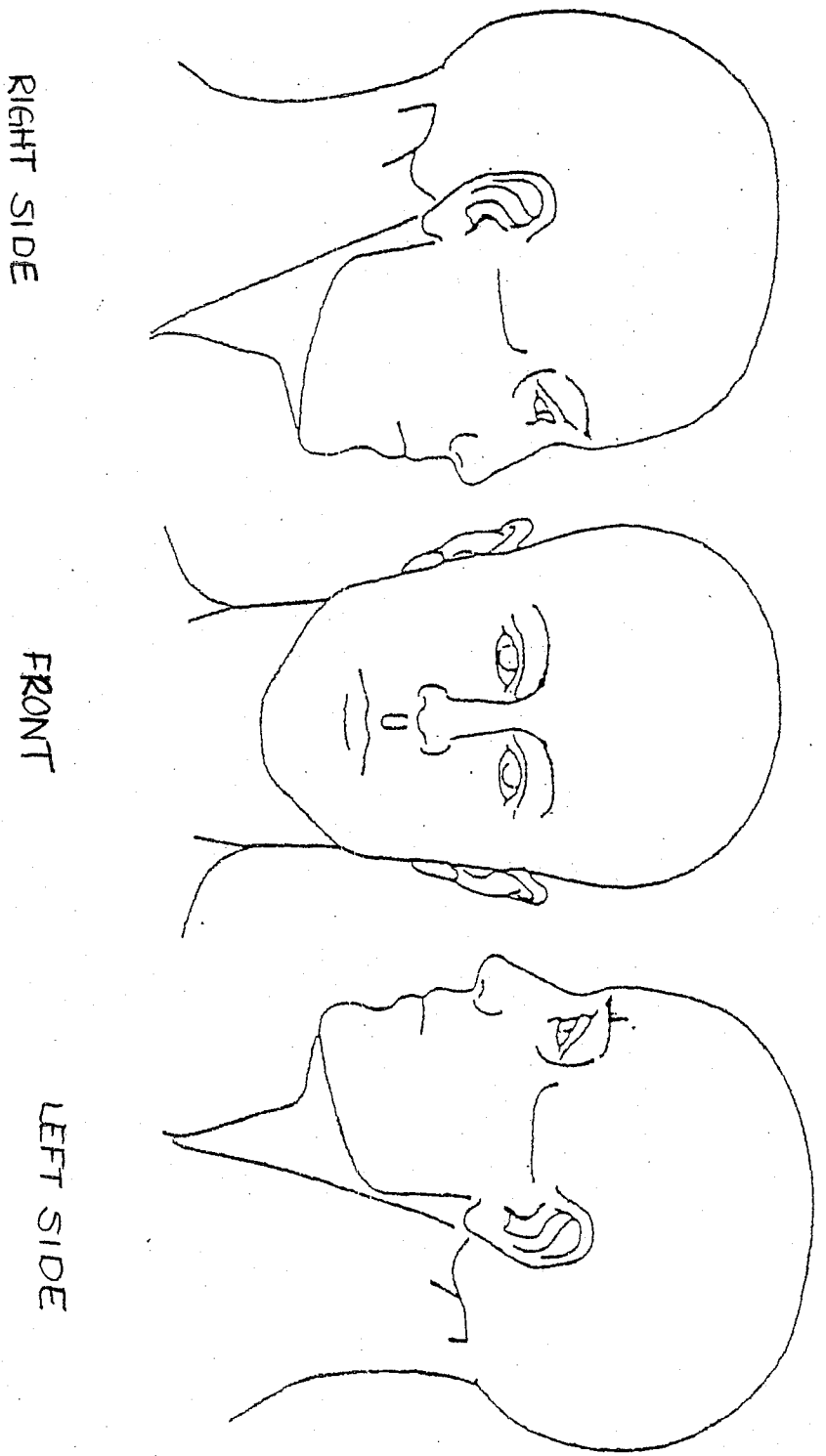
PAIN HISTORY



NORTHSHORE INTERVENTIONAL PAIN MANAGEMENT CENTER

PAIN HISTORY

How would you describe your pain?
Some of the words below describe your pain. Circle only those words that best describe it. Leave out any category that is not suitable. Use only one word in each appropriate category that applies to you.

1	2	3	4
FIICKERING	JUMPING	PRICKING	SHARP
QUIVERING	FLASHING	BORING	CUTTING
PULSING	SHOOTING	DRILLING	LACERATING
THROBBING		STABBING	
BEATING		LANCINATING	
POUNDING			

5	6	7	8
PINCHING	TUGGING	HOT	TINGLING
PRESSING	PULLING	BURNING	ITCHY
GNAWING	WRENCHING	SCALDING	SMARTING
CRAMPING		SEARING	STINGING

9	10	11	12
DULL	TENDER	TIRING	SICKENING
SORE	TAUT	EXHAUSTING	SUFFOCATING
HURTING	RASPING		
ACHING	SPLITTING		
HEAVY			

13	14	15	16
FEARFUL	PUNISHING	WRETCHED	ANNOYING
FRIGHTFUL	GRUELING	BLINDING	TROUBLESOME
TERRIFYING	CRUEL		MISERABLE
	VICIOUS		INTENSE
	KILLING		UNBEARABLE

17	18	19	20
SPREADING	TIGHT	COOL	NAGGING
RADIATING	NUMB	COLD	NAUSEATING
PENETATIG	DRAWING	FREEZING	AGONIZING
PIERCING	SQUEEZING		DREADFUL
	TEARING		TORTURING

To the best of my knowledge, I have answered all questions correctly.

Signature Date