UNIVERSITY Pain Clinic

PAIN DATA PATIENT HISTORY

Name:_____ Social Security No.: _____

Address:_____

City/State/Zip:_____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Birth Date: _____ Age: _____ Country Of Birth: _____ Sex: Male Female

Marital Status: (circle one) Single Married Widowed Separated Divorced Significant other

Number of Children and Ages:_____

Referral and Physician Information

Referred By:_____ Phone: ( ) _____

Complete Address:_____

Primary Care Physician:_____ Phone: ( ) _____
(if not listed above)
Complete Address: _____

Problem (Pain) Information

Reason for appointment/chief complaint:_____

_____

_____

_____

What do you expect from the treatment at University Pain Clinic? (Please be as specific as possible)

_____

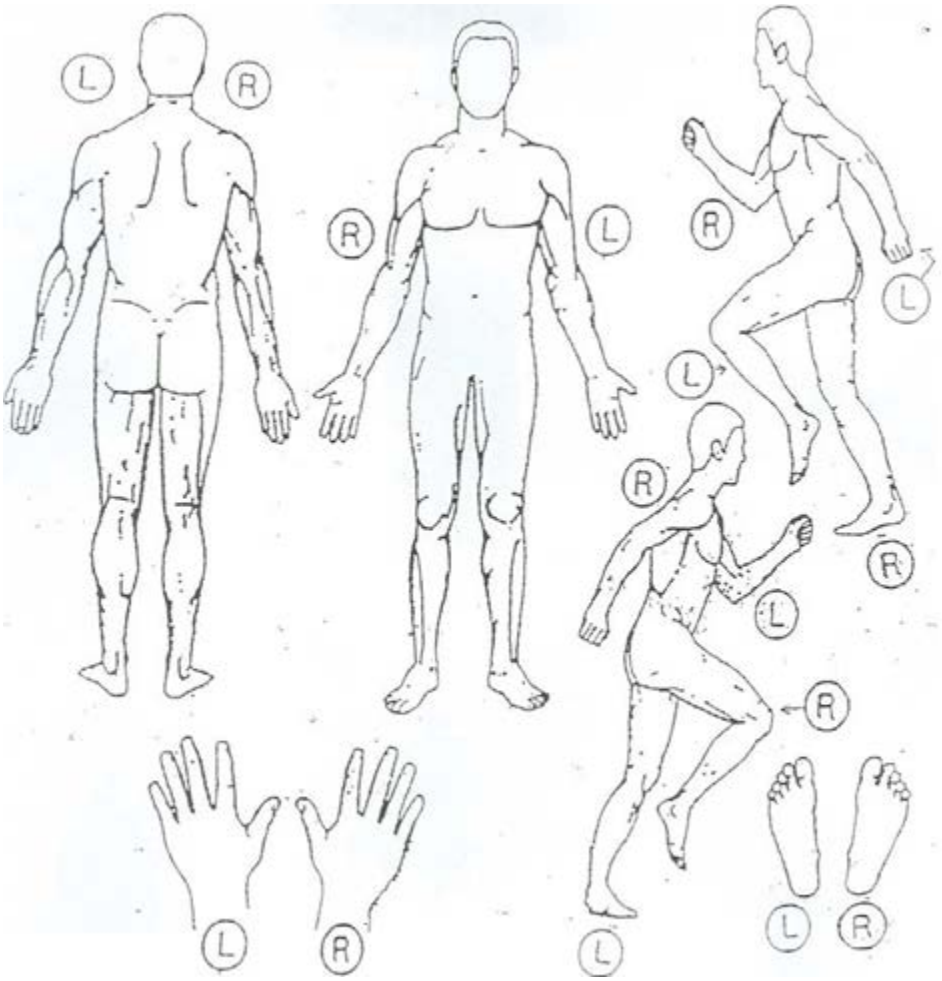
_____

_____

Is your pain the result of an automobile accident?	Yes	No	Unsure
Is your pain work related?	Yes	No	Unsure
Are you considering starting a lawsuit because of your pain?	Yes	No	Unsure
Are you currently in litigation because of your pain?	Yes	No	Against Whom?_____
Have you completed pain-related litigation?	Yes	No	

Mark the area(s) on your body where you feel the described sensations. Use the appropriate symbols. Mark any areas of radiation (where pain may travel to). Include all affected areas.

Aching	Numbness	Pins &Needles	Burning	Stabbing
^^^^^^	----------	oooooooooo	xxxxxxxxxx	//////////////
^^^^^^	----------	oooooooooo	xxxxxxxxxx	//////////////



Please Describe Your Pain In Your Own Words Under The Following Headings:

1. When did you first experience the pain for which you are now seeking help?_____

_____

2. Site (Where is the main focus?) _____

_____

3. Radiation (Does it spread to other parts of the body?) _____

_____

4. Texture (sharp, dull, burning, aching, etc.) _____

_____

5. Duration/Frequency (How long has it been present, how long it lasts, how often) _____

_____

6. Intensity (Does it vary in strength?) _____

_____

7. Relieving Factors (rest, medication, sitting, etc.) _____

_____

8. Causes of increase (+) or decrease (-) of pain. Indicate with + or – at appropriate cause.

_____ Liquor (Alcohol)	_____ Movement	_____ Standing
_____ Stimulants (coffee, etc.)	_____ Lying Down	_____ Sitting or Driving
_____ Eating	_____ Distractions	_____ Tension
_____ Heat/Cold	_____ Urinations/Bowel Movement	_____ Stress
_____ Dampness	_____ Bright Lights	_____ Loud Noises
_____ Weather Changes	_____ Going to Work	_____ Sexual Relations
_____ Massage, Vibrator	_____ Mild Exercise	_____ Coughing/Sneezing
_____ Going Up Stairs	_____ Going Down Stairs	_____ Pressure

_____ Other _____

9. Do you think that the pain is due to something more serious or different from what other doctors have told you? _____ Yes _____ No What do you think is the cause of the pain? (Describe briefly)

_____

_____

10. Have doctors ever suggested that your pain was imaginary or "all in your head"? _____Yes _____ No

11. Under what circumstances did the pain begin?

_____ Accident at work _____ At work, but not an accident _____ Accident at home

_____ Other accident _____ Following surgery _____ Pain just began, can't relate it to anything

_____ Other reason or circumstances (list) _____

12. In what part (s) of the body did the pain begin? (name all parts) _____

_____

13. Since the onset of your pain condition, which of the following people have you consulted for treatment and pain relief?

____ Acupuncturist	____ Allergist	____ Anesthesiologist
____ Internal Medicine (internist)	____ Endocrinologist (glandular disorders)	____ Otorhinolaryngologist (ear, nose & throat)
____ Hypnotist	____ Neurologist	____ Neurosurgeon
____ Dentist	____ Clergyman	____ Dermatologist (skin)
____ Osteopath	____ Orthopedist (bone & joint)	____ Rheumatologist
____ Faith Healer	____ Nutritionist	____ General/Family Doctor
____ Gynecologist	____ Plastic Surgeon	____ Pediatrician
____ General Surgeon	____ Psychiatrist	____ Radiologist
____ Psychologist	____ Urologist	____ Physiatrist
____ Other (specify)		

14. What part (s) of the body now hurt when you experience pain? (as in site) _____

_____

15. Whenever the pain occurs, do you also experience difficulties or changes in other parts of the body? For example, if pain is in the upper arm, does it cause twitching in the fingers? Describe what happens, when it happens, and how often it happens. _____

_____

_____

16. The pain is:

_____ Rarely present _____ Under certain circumstances _____ Frequently present

_____ Usually present _____ Always present

17. Is the intensity of the pain always the same, or is it sometimes worse? _____ Same _____ Worse

Describe: _____

_____

18. Using the 0 (no pain) to 10 (worst possible pain) pain scale, answer the following questions.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Discomfort		Distress		Horrible		Worse Pain

Circle the Numbers below

Your pain as it usually feels	1	2	3	4	5	6	7	8	9	10
Your pain right now	1	2	3	4	5	6	7	8	9	10
Your pain at its worse	1	2	3	4	5	6	7	8	9	10
Your pain when it hurts least	1	2	3	4	5	6	7	8	9	10
The worst toothache you've ever had	1	2	3	4	5	6	7	8	9	10
The worse headache you've ever had	1	2	3	4	5	6	7	8	9	10
The worse sunburn you've ever had	1	2	3	4	5	6	7	8	9	10

19. Do you have trouble falling asleep? _____ Never _____ Sometimes _____ Usually _____ Always

On average, how many hours per night do you sleep? _____

Do you sleep during the day? _____ No _____ Yes

Do you take medicine to help you fall asleep? _____ Never _____ Sometimes _____ Usually _____ Always

If you take medicine to sleep, is the medication prescribed/recommended by the doctor?

Doctor Prescribed ____ Yes ____ No Self Prescribed ____ Yes ____ No

What is the sleeping medication that you take? _____

Do you awaken early in the morning? ____ Yes ____ No

Do you feel rested? ____ Yes ____ No

20. Does the pain frequently wake you at night? ____ Yes ____ No

If yes, how many times during the night? _____

When it wakes you, what do you do then? ____ Empty bladder ____Take medication ____ Sit up awhile

Other (describe) _____

21. What does your husband, wife, significant other do when you wake up at night with pain? (be specific)

_____

22. What activities bring on the pain or make it worse? _____

23. About how long after beginning this activity does it take the pain to begin to get worse? _____

_____

Does the pain leave if you stop this activity? ____ Yes ____ No

How many times a day is the pain likely to interfere with your activities? _____

24. How effective is the pain medication?

_____ Always takes pain away	_____ Usually takes pain away
_____ Always makes pain less	_____ Usually makes pain less
_____ Frequently makes pain less	_____ Sometimes takes pain away
_____ Makes me feel sleepy	_____ No effect at all
_____ Other _____	

What is the longest time that the medicine relieves the pain, either entirely or minimal pain? _____

What medicines do you take for your pain? (include over the counter medications) _____

_____

_____

25. How often do you usually drink alcoholic beverages? (Includes beer and wine)

____ Never drink alcohol	____ Less than once a week	____ Once a week
____ 2-3 times a week	____ 3-6 times a week	____ Every day

Do you use Alcohol to:

Help you relax	____ Never	____ Sometimes	____ Frequently	_____ Usually
Help you sleep	____ Never	____ Sometimes	____ Frequently	_____ Usually
Help relieve pain	____ Never	____ Sometimes	____ Frequently	_____ Usually

26. How many physicians have you go to for this problem? ____

Do you feel that the doctors who have treated you have been sympathetic and understanding?

____ Very sympathetic ____ Somewhat sympathetic ____ Hardly sympathetic ____ Not at all sympathetic
____ Very understanding ____ Somewhat understanding ____ Hardly understanding ____ Not at all understanding

27. How would you rate your overall satisfaction with the care and treatment you have received for your pain to date?

____ Very satisfied ____ Somewhat satisfied ____ Barely satisfied ____ Dissatisfied ____ Very dissatisfied

28. If your treatment here does not bring you relief, do you think you will try elsewhere? ____ Yes ____ No

ADDITIONAL COMMENTS YOU MAY CARE TO MAKE: _____

_____

_____