Pain History

1. What is the reason for your visit today? _____
2. How long have you had this pain? _____
3. How did your current pain start? _____
4. Work related YES/NO Car Accident YES/NO

   If yes, is the case open or closed? _____
5. How often do you have pain? _____
6. When is your pain at its worst (Please circle all that applies)

   ___ Morning ___ Afternoon __ Evening ___ Night ___ No Typical pattern
6. Are there any factors that make your pain better (Please circle all that apply)

   ___ sitting ___ standing ___ walking ___ lying down ___ Nothing Other_____
7. Are there any factors that make your pain worse?

   ___ sitting ___ standing ___ walking ___ lying down ___ Nothing Other_____
8. Have you seen any other Doctor/Specialist for this pain? _____

   _____

   _____
9. Please list all of the medications **you have ever tried** for your current pain _____

   _____

   _____
10. What medication do you take **now** for your pain and who prescribed it? _____

    _____

    _____
11. Please check all of the treatments you have tried below.

	Dates	Did it help
__ Hospital Bed rest		
__ Traction	_____	_____
__ Surgery	_____	_____
__ Acupuncture	_____	_____
__ TENS (Electrical Stimulator)	_____	_____
__ Physical Therapy	_____	_____
__ Chiropractor	_____	_____
__ Epidural Injections	_____	_____
__ Nerve Block	_____	_____
__ Transforaminal Injections	_____	_____
__ Exercise	_____	_____

__ Other: _____

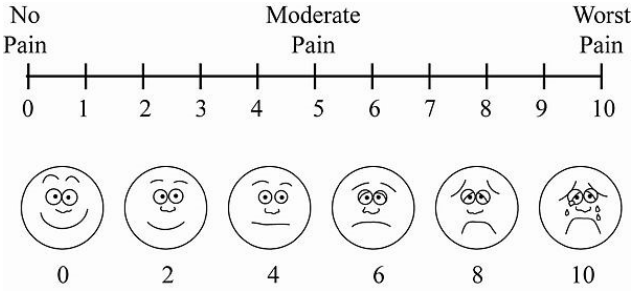
12. Have you had any CT scans or MRI for your current pain? (Circle) Yes No

    If yes, at what facility? _____

Signature:_____ Date: _____

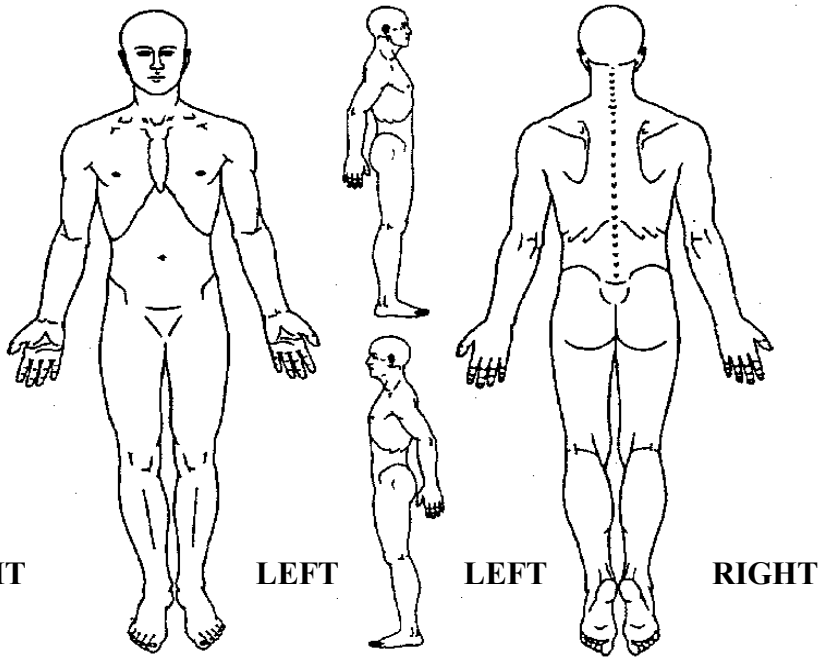
PAIN INVENTORY

Pain Level Now:_____
Pain Level at its worst: _____
Pain level you can live with: _____



Please mark the area of injury or discomfort on the chart below, with an X

Please Check (✓)
- ☐ Aching
- ☐ Burning
- ☐ Cramps
- ☐ Dull
- ☐ Electric
- ☐ Numbness
- ☐ Sharp
- ☐ Shooting
- ☐ Stabbing
- ☐ Stiffness
- ☐ Swelling
- ☐ Throbbing
- ☐ Tingling



Patient Name: _____ Date: _____