

NORTHSHORE INTERVENTIONAL PAIN MANAGEMENT CENTER

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 Thyroid disorder
Yes No Pacemaker	Yes No Hepatitis, jaundice,liver disease
Yes No High Blood Pressure	Yes No Asthma
Yes No CVA (Stroke)	Yes No Tuberculosis
Yes No Dizziness	Yes No Other Pulmonary disease
Yes No Arthrtis	Yes No Cancer
Yes No Anemia	Yes No GU/bladder/prostate problems
Yes No Previous Blood Transfusion	Yes No Rheumatic Fever
Yes No Measles	Yes No Glaucoma
Yes No Mumps	Yes No Kidney disease
Yes No Chicken pox	Yes No Skin Disorder/Rash
Yes No ENT Problems	Yes No Transplant
Yes No Cataracts	Yes No Mitral Valve Prolapse
Yes No Are you pregnant?	Last menstrual period_____
Yes No Are you trying to get pregnant?	
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 Sexually transmitted disease
Yes No Do you drink?	Yes No Immunizations up to date?
Type/amount: _____	Yes No Communicable disease exposure
Yes No Anesthesia problems	Yes No Psychiatric / mental disorder
	Yes No Sickle Cell disease/ trait
Level of Education:_____	Yes No Seizures
Yes No Dentures/ partial/ other	Yes No Diabetes
Yes No Visual problems/ glasses	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



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: alcohol use tobacco use marital status

List any new medications / medications stopped since last visit: _____

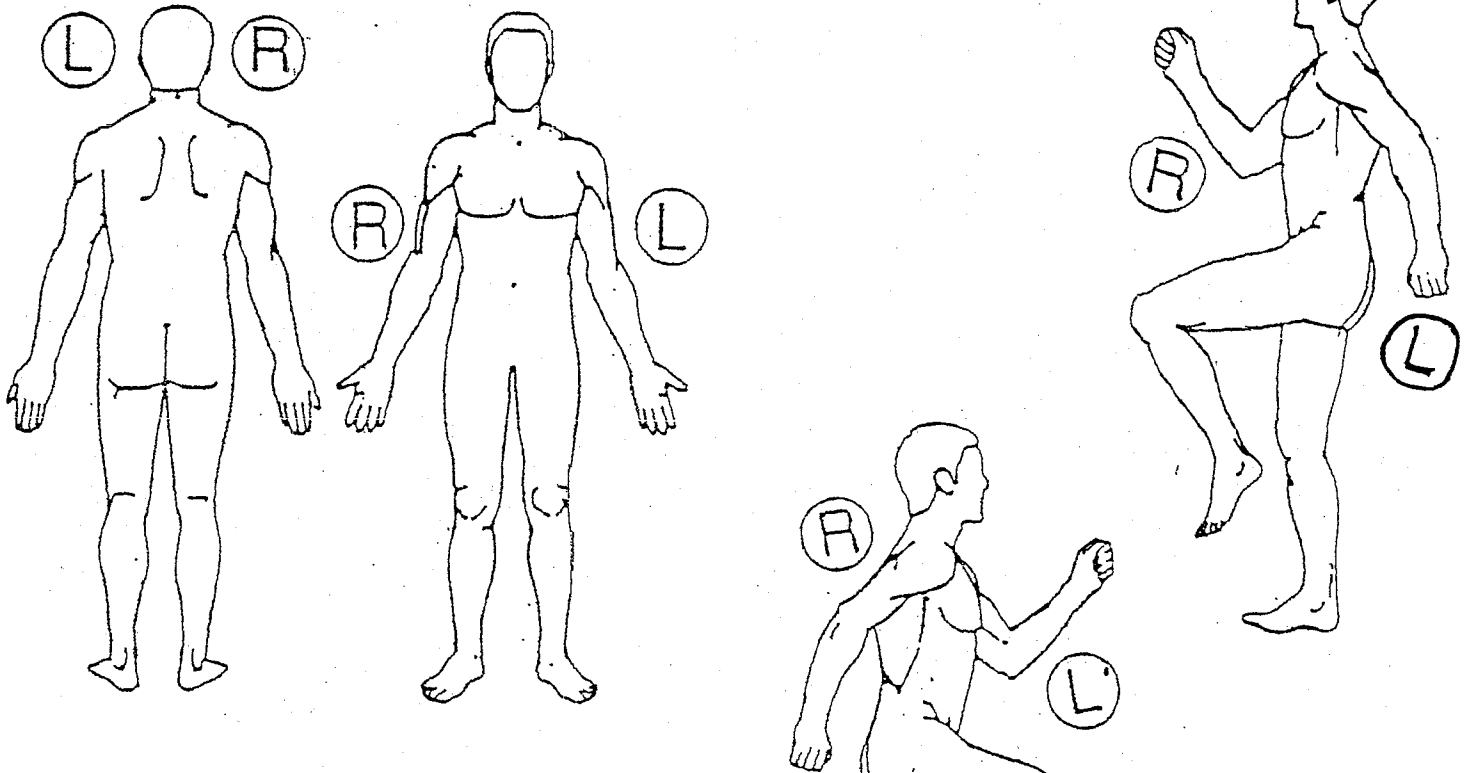
List any surgical procedures since last visit: _____

Patient Signature _____ Date _____

NORTHSHORE INTERVENTIONAL PAIN MANAGEMENT CENTER

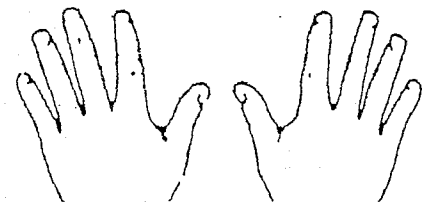
PAIN HISTORY

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.

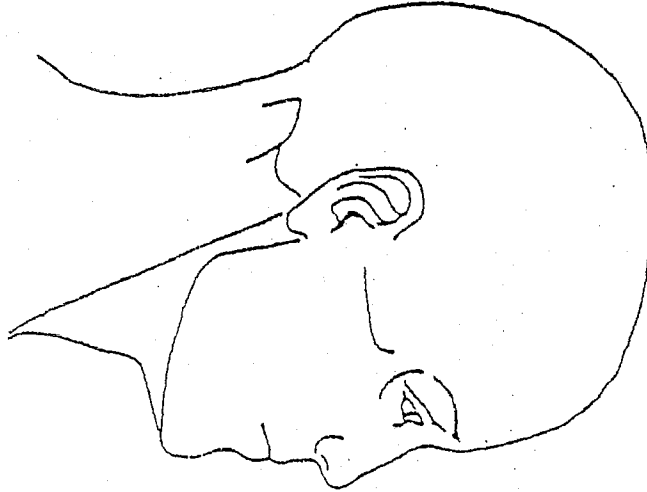
- | | |
|--|--|
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Left Ankle or Foot |
| <input type="checkbox"/> Mid Back | <input type="checkbox"/> Right Ankle or Foot |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Left Shoulder |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Right Shoulder |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Left Arm |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Right Arm |
| <input type="checkbox"/> Groin | <input type="checkbox"/> Left Hand or Wrist |
| <input type="checkbox"/> Left Buttock | <input type="checkbox"/> Right Hand or Wrist |
| <input type="checkbox"/> Right Buttock | <input type="checkbox"/> Head |
| <input type="checkbox"/> Left Thigh | <input type="checkbox"/> Face |
| <input type="checkbox"/> Right Thigh | <input type="checkbox"/> Other (List) |
| <input type="checkbox"/> Left Calf | _____ |
| <input type="checkbox"/> Right Calf | _____ |



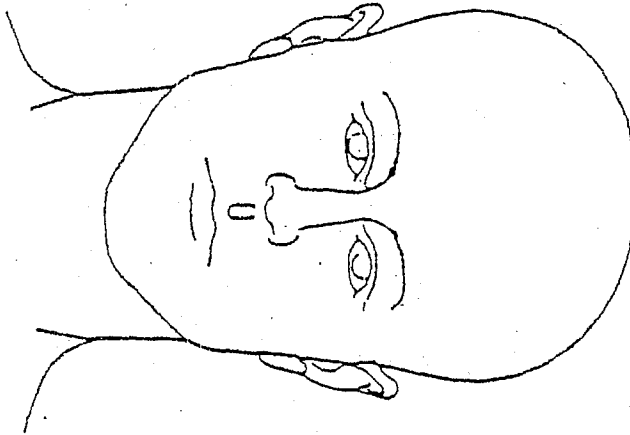
NORTHSHORE INTERVENTIONAL PAIN MANGEMENT CENTER

PAIN HISTORY

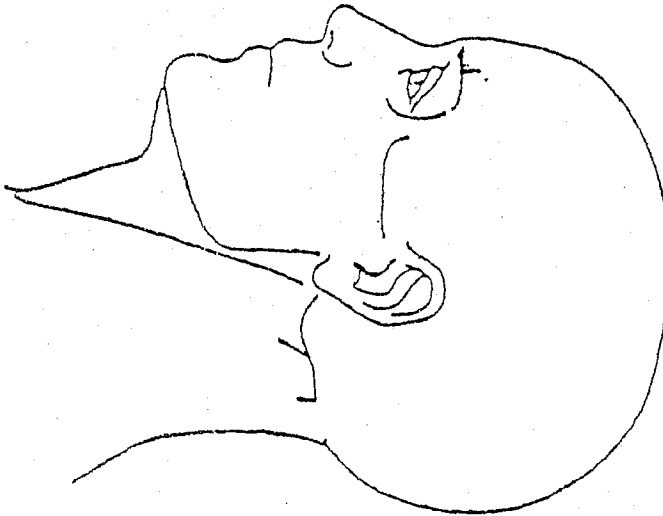
RIGHT SIDE



FRONT



LEFT SIDE



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
FLICKERING
QUIVERING
PULSING
THROBBING
BEATING
POUNDING

2
JUMPING
FLASHING
SHOOTING

3
PRICKING
BORING
DRILLING
STABBING
LANCINATING

4
SHARP
CUTTING
LACERATING

5
PINCHING
PRESSING
GNAWING
CRAMPING

6
TUGGING
PULLING
WRENCHING

7
HOT
BURNING
SCALDING
SEARING

8
TINGLING
ITCHY
SMARTING
STINGING

9
DULL
SORE
HURTING
ACHING
HEAVY

10
TENDER
TAUT
RASPING
SPLITTING

11
TIRING
EXHAUSTING

12
SICKENING
SUFFOCATING

13
FEARFUL
FRIGHTFUL
TERRIFYING

14
PUNISHING
GRUELING
CRUEL
VICIOUS
KILLING

15
WRETCHED
BLINDING

16
ANNOYING
TROUBLESOME
MISERABLE
INTENSE
UNBEARABLE

17
SPREADING
RADIATING
PENETRATING
PIERCING

18
TIGHT
NUMB
DRAWING
SQUEEZING
TEARING

19
COOL
COLD
FREEZING

20
NAGGING
NAUSEATING
AGONIZING
DREADFUL
TORTURING

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

Signature

Date