Patient Case History

Name_____ Date_____/_____/20____

Address_____State_____Zip_____

Home Ph.( )_____Cell Ph.( )_____ Date of Birth_____/_____/_____ Age_____

Referred by_____ Social Security #_____ - ___ - _____ Sex M F Other_____

Occupation_____ Employer_____

Have you ever received Pain Management? Yes No If yes, when?_____
Where?_____

1. Primary reasons for seeking Pain Management care:

Primary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____
_____
_____

4. Past Health History:
A. Previous illnesses you've had in your life: _____
_____

B. Previous injury or trauma:_____
_____
Have you ever broken any bones? Which? _____

C. Allergies (Medicatios/ Food)_____

D. Medications: Currently Taking

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

6. Social and Occupational History:

A. Level of Education:

O high school O some college O college graduate O post graduate studies

B. Job description: _____

C. Work schedule: _____

D. Recreational activities: _____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with care, in accordance with this state's statutes.

Parent or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____

Please add any additional information here: