Midwest Pain Care

Patient Information

Appointment date: ____________________

Your name: ____________________________ Date of Birth: ____________ Age: _____________

Referring Physician: ____________________ Primary Care Physician: ______________________

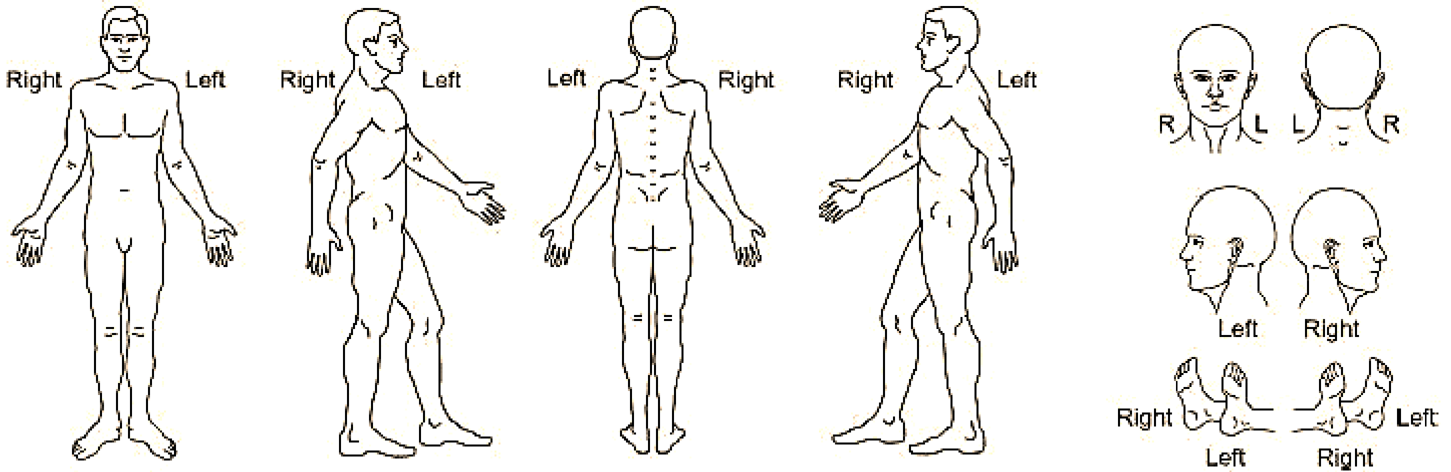
Pain History

Reason for your visit today: ____

Does this pain spread to another area? If so where? ____________________________________

Please list any additional areas of pain: ____

Use this diagram to indicate the area of your pain. Mark the location(s) with an "X"



Onset of Symptoms

Approximately when did this pain begin? ____

What caused your current pain episode? ____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ No change

Pain Description

Check all of the following that describe your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp

☐ Cramping ☐ Numbness ☐ Spasms ☐ Throbbing

☐ Squeezing ☐ Tingling/Pins and Needles ☐ Tightness

When is your pain at its worst?

☐ Mornings ☐ Daytime ☐ Evenings ☐ Middle of the night

☐ Always the same

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present

☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now__________ The Best It Gets__________ The Worst It Gets_________

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Mark the effect each of the following has on your pain level:	Increases	Decreases	No Change
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking upward	☐	☐	☐
Looking downward	☐	☐	☐
Rising from seated position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

What other factors worsen or affect your pain which is not mentioned above?

____

Associated Symptoms	Yes	No	Comments
Numbness/Tingling	☐	☐	Where?
Weakness in the arm/leg	☐	☐	
Balance Problems	☐	☐	
Bladder Incontinence	☐	☐	
Bowel Incontinence	☐	☐	
Joint Swelling/Stiffness	☐	☐	
Fevers/chills	☐	☐	

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Indicate treatments tried for pain relief:	Worsened Pain	Helped Pain	No Change
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐

Other treatments tried:____

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Indicate interventional treatments tried for pain relief:

☐ Epidural Steroid Injections (circle levels): ☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Joint Injection(s) (where): ______
☐ Facet Injections/Medial Branch Blocks (circle levels): ☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Disc Procedures (decompression, discogram) : ______
☐ Nerve Blocks (what nerve, where?): ______
☐ Radiofrequency Nerve Ablation (circle levels): ☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Spinal Cord Stimulator: ☐ Trial Only ☐ Permanent Implant
☐ Trigger Point Injections (where?): ______
☐ Vertebroplasty/Kyphoplasty (location/levels): ______
☐ Other: ______

Which of these procedures listed above have helped with your pain? ______

Please list any past pain providers seen: ______

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

☐ MRI of the: ______ Date: ______
☐ X-Ray of the: ______ Date: ______
☐ CT Scan of the: ______ Date: ______
☐ EMG/NCV: ______ Date: ______
☐ Other Diagnostic Testing: ______ Date: ______
☐ I have not had any diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist ☐ Neurosurgeon ☐ Psychiatrist/Psychologist
☐ Chiropractor ☐ Orthopedic Surgeon ☐ Rheumatologist
☐ Internist ☐ Physical Therapist ☐ Neurologist
☐ Other: ______

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Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ☐ Cancer
- ☐ Diabetes
- ☐ HIV/AIDS
- ☐ MRSA/VRE

Head/ENT
- ☐ Headaches
- ☐ Migraines
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Glaucoma

CV/Hematologic
- ☐ Anemia
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Valve Disease
- ☐ Murmur
- ☐ Phlebitis
- ☐ Poor Circulation
- ☐ Stroke
- ☐ Coronary Art. Disease

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema/COPD
- ☐ Pneumonia
- ☐ Tuberculosis

Gastrointestinal
- ☐ Bowel Incontinence
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Constipation

Musculoskeletal
- ☐ Amputation
- ☐ Bursitis
- ☐ Carpal Tunnel
- ☐ Chronic Back Pain
- ☐ Chronic Neck Pain
- ☐ Chronic Joint Pain
- ☐ Fibromyalgia
- ☐ Joint Injury
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Phantom Limb Pain
- ☐ Rheumatoid arthritis
- ☐ Vertebral Fracture

Genitourinary/Renal
- ☐ Bladder Infection(s)
- ☐ Dialysis
- ☐ Kidney Infection(s)
- ☐ Kidney Stones
- ☐ Urinary Incontinence

Hepatic
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Neuropsychological
- ☐ Alcohol Abuse
- ☐ Alzheimer Disease
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Epilepsy
- ☐ Drug Abuse
- ☐ Drug Misuse
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Peripheral Neuropathy
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Complex Regional Pain Syndrome
- ☐Other Conditions: ______________________

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Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) ______________________________ Date: __________
2) ______________________________ Date: __________
3) ______________________________ Date: __________
4) ______________________________ Date: __________
5) ______________________________ Date: __________

☐ I have NEVER had any surgical procedures performed.

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones? ☐ Aspirin ☐ Coumadin ☐ Elaquis ☐ Plavix
☐ Lovenox ☐ Xarelto ☐ Other: __________

Please list all medications you are currently taking including vitamins and supplements. Attach additional sheet if required:

	Medication Name	Dose	Frequency
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Please list any pain medications you have tried in the past for your current complaint:

	Medication Name	Dose	Frequency
1)			
2)			
3)			
4)			
5)			

Allergies

Do you have any known drug allergies? (list below) ☐ Yes ☐ No

Medication Name	Reaction
1)	
2)	
3)	
4)	
5)	

Do you have any allergies to the following?

☐ Contrast ☐ Latex ☐ Tape ☐ Iodine ☐ Chlorhexidine

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Family Medical History

Mark all appropriate diagnoses as they pertain to your mother or father:

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Headaches
☐ High Blood Pressure ☐ Kidney Problems ☐ Liver Problems ☐ Osteoporosis
☐ Rheumatoid arthritis ☐ Seizures ☐ Stroke
☐ Other Medical Problems: ______________________________
☐ I have no significant family medical history

Social History

Are you or can you be pregnant? ☐ NA ☐ Yes ☐ No
Number of Children: ____________ Number of Children Living at Home: ________________
Highest level of education: ☐ Grammar school ☐ High School ☐ College
Alcohol Use: ☐ Daily Limited Use ☐ History of Abuse ☐ Current Abuse
☐ Never Drink ☐ Drink Socially
Tobacco Use: ☐ Current Use ☐ Former User ☐ Never Used Tobacco
Illegal Drugs: ☐ Denies Any Use ☐ Illegal Drug Use ☐ Current Marijuana
☐ Currently Using Someone Else's Prescription Medications
☐ Formerly Used Illegal Drugs (not currently using)
Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

Review of Systems

Mark any symptoms you are currently experiencing:

Constitutional:	☐ Chills ☐ Difficulty Sleeping ☐ Easy Bruising ☐ Excessive Sweating ☐ Excessive Thirst ☐ Fatigue ☐ Fevers ☐ Insomnia ☐ Low Sex Drive ☐ Night Sweats ☐ Tremors ☐ Weakness ☐ Unexplained Weight Gain ☐ Unexplained Weight Loss
Eyes:	☐ Recent Visual Changes
Ears/Nose/Throat/Neck:	☐ Dental Problems ☐ Earaches ☐ Hearing Problems ☐ Nosebleeds ☐ Recurrent Sore Throats ☐ Ringing in the Ears ☐ Sinus Problems
Cardiovascular:	☐ Bleeding Disorder ☐ Chest Pain ☐ Deep Vein Thrombosis ☐ Fainting ☐ High Blood Pressure ☐ Irregular Heartbeat ☐ Lightheadedness ☐ Shortness of Breath During Sleep ☐ Swelling in the Feet
Respiratory:	☐ Cough ☐ Wheezing ☐ Pulmonary Embolism ☐ Shortness of Breath on Exertion/Effort ☐ Shortness of Breath at Rest

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Gastrointestinal:	☐ Abdominal Cramps ☐ Acid Reflux ☐ Constipation ☐ Coffee Ground Vomit ☐ Dark and Tarry Stools ☐ Diarrhea ☐ Hernia ☐ Vomiting
Musculoskeletal:	☐ Back Pain ☐ Joint Stiffness ☐ Joint Pain ☐ Joint Swelling ☐ Muscle Spasms ☐ Neck Pain
Genitourinary/Renal:	☐ Blood in Urine ☐ Decreased Urine Flow/Frequency/Volume ☐ Flank Pain ☐ Painful Urination
Neurological:	☐ Carpal Tunnel Syndrome ☐ Dizziness ☐ Headaches ☐ Numbness/Tingling ☐ Instability When Walking ☐ Tremors ☐ Seizures
Psychiatric:	☐ Depressed Mood ☐ Feeling Anxious ☐ Stress Problems ☐ Suicidal Thoughts ☐ Suicidal Planning

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