New Patient Pain History Form

Name: _____ Date of birth: _____/_____/_____ Today's date: _____/_____/_____

Date the pain began: _____/_____/_____ Dominant hand (please circle one): Right or Left

Reason for visit:

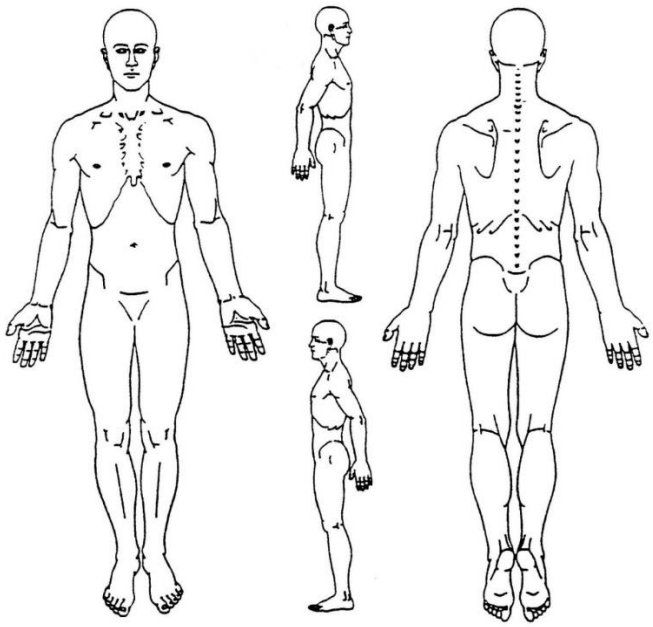
_____
_____
_____
_____

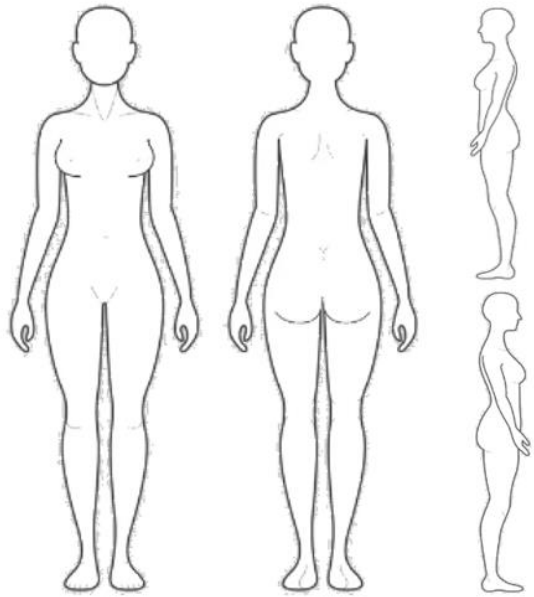
Describe what caused the pain (accident, injury, etc.):

_____
_____
_____

Symptoms

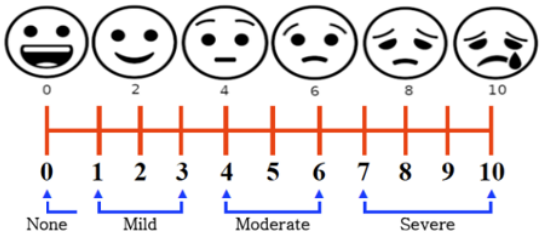
1. Mark the areas on your body where you feel symptoms by placing a **X** by where you are most affected.





2. How would you describe the kind of pain or symptoms that you have:
   ☐ Sharp ☐ Stabbing ☐Aching ☐ Dull ☐ Burning ☐ Cramping ☐ Pins and needles ☐ Throbbing
   ☐ Numbness – If so, where? _____
   ☐ Weakness – If so, where? _____

3. How is your pain compared to when it first started?
   ☐Improved by _____ ☐Worsened by _____ ☐No Change



4. Pain Severity: If "0" is no pain and "10" is the worst pain imaginable, please note your pain over the <u>past two weeks</u> by circling the appropriate number:

Pain at its worst:	[0 1 2]	[3 4 5 6 7]	[8 9 10]
	Mild	Moderate	Severe
Pain at its least:	[0 1 2]	[3 4 5 6 7]	[8 9 10]
	Mild	Moderate	Severe
Pain on average:	[0 1 2]	[3 4 5 6 7]	[8 9 10]
	Mild	Moderate	Severe

   Pain frequency: ☐Constant ☐It comes and goes

   How many hours in a day are you in pain? _____

   Time of day pain is at its worst: ☐ Morning ☐Afternoon ☐Evening ☐Nighttime

   How often you stop activity due to pain:

   ☐ Never ☐ Rarely ☐ Occasionally ☐ Several times a day ☐ I spend most of the day lying or sitting

5. Activities that help lower the pain:
   _____

6. Activities that make the pain worse:
   _____

7. Medications you take to relieve pain (please list all):
   _____
   _____

8. Current exercise activities:
   _____

Diagnostic tests performed for this condition:

Test	Date	Location
☐ X-Rays	_____	_____
☐ CT Scan	_____	_____
☐ MRI	_____	_____
☐ Bone Scan	_____	_____
☐ EMG (nerve test)	_____	_____
☐ Other	_____	_____

List the doctors (Primary Care, Specialist, Osteopathic Specialist, Chiropractor, or Therapist) you have seen in the last year for your condition:

Doctor's Name	Type of Doctor	Location	Approximate Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Effect of treatment(s) you have had, or are currently receiving, for your pain:

Treatment	Helped	Made Things Worse	No Difference	Currently Receiving
Heat	☐	☐	☐	☐
Ice	☐	☐	☐	☐
Ultrasound	☐	☐	☐	☐
Massage	☐	☐	☐	☐
TENS Unit (Electrical Stimulation)	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐
Epidural Injections	☐	☐	☐	☐
Back Brace	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐
Mental Healthcare	☐	☐	☐	☐
Chiropractic Care	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

LEGACY HEALTH

New Patient Health History Form

Name: _____ Date of birth: ___/___/_____ Today's date: ___/___/_____

PCP: _____

Allergies and Medications:

Medication allergies:

_____

List any other allergies:

_____

Current Medications:

Medication	Dose/Frequency	Used to Treat	For How Long?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History (please check those which apply):

□Hypertension	□Chronic Pain (>3 months)	□Anxiety
□Heart Disease	□Diabetes Mellitus	□Substance Abuse
□Hyperlipidemia	□GERD/Ulcers/Gastritis	□Cancer
□Nerve/Muscle disease	□Depression	□Work Related Injury
□Stroke	□Motor Vehicle Accident	□Fractures
□Seizures	□Thyroid Disease	□DVT
□Migraine	□Pulmonary	□Prostate Problems
□Fibromyalgia	□Kidney Disease	

□Nerve/Muscle Disease (please specify):

_____

Any other relevant medical history:

_____

Family History (please place a check mark indicating relation of relative)

Status:	Alive	Deceased	Unknown	No Known Issues	Arthritis	Cancer	Depression	Diabetes	Early Death (<50yo)	Heart Disease	High Blood Pressure	Lung Disease	Neurological Disorder	Osteoporosis	Stroke	Spine Problems	Drug/Alcohol Abuse	Thyroid Disease
Mother																		
Father																		
Sister																		
Brother																		
Maternal Grandmother																		
Maternal Grandfather																		
Paternal Grandmother																		
Paternal Grandfather																		
Daughter																		
Son																		

Other relevant family history:

_____

Surgical History (please check those which apply and provide approximate year performed):

□Appendectomy _____ □Gall Bladder _____ □Neck Surgery _____

□Back Surgery _____ □Heart Surgery _____ □Orthopedic and/or Joint

□Breast Surgery _____ □Hernia Repair _____ □Surgery _____

□C-Section _____ □Hysterectomy _____ □Tonsillectomy _____

Any other relevant surgical history:

_____

Social History

1. Marital status: □Married □Domestic Partner □Widowed □Never Married □Divorced/Separate
   Whom do you live with: □Spouse □Children □Parents □Roommate(s)
   □Partner □Alone □Other _____
2. Highest grade or level of education completed: _____
3. Tobacco Use: □Never □Current □Former (Quit Date:_____)
   a. Type(s) of tobacco used: □Cigarettes □Cigars □Pipe □Chewing Tobacco
   b. Average number of packs per day: _____ Age when started using tobacco: _____

4. Cups of coffee per day? _____ Cups of other caffeinated beverages per day? _____

5. Do you use alcohol? □Yes □No
   a. If yes, average number of alcoholic beverages per week: _____
   b. Times in the past year you consumed 4+ drinks in one day: _____
   c. Do you use alcohol to control your pain? □Yes □No

6. Drugs you have used:
   a. at any time: □Stimulants □Hallucinogens □Marijuana □Cocaine □Meth □None of these
   b. in the past 12 months: □Stimulants □Hallucinogens □Marijuana □Cocaine □Meth □None of these

7. Are you currently employed? □Yes □No
   a. If so, how many hours per week do you work? _____
   b. Where do you work? _____
   c. What type of work do you do? _____

8. Are you currently on disability or involved in a disability claim? □Yes □No

9. Are you currently involved in a legal claim? □Yes □No
   a. If so, are you represented by an attorney? □Yes □No

   If yes, please provide name: _____

Review of Symptoms (Check all those which apply):

☐ Low Back Pain	☐ Dizziness	☐ Fever	☐ Wheezing
☐ Joint Pain	☐ Headaches	☐ Weight Loss	☐ Coughing
☐ Joint Swelling	☐ Urinary Frequency	☐ Night Sweats	☐ New Rash
☐ Muscle Pain	☐ Vision Change	☐ Psoriasis (scaly rash)	☐ Anxiety
☐ Shortness of Breath	☐ Chest Pain	☐ Night Pain	☐ Double Vision
☐ Skin Breakdown	☐ Weakness	☐ Numbness	☐ Heart Palpitation
☐ Depressed Mood	☐ Tingling	☐ Nausea	☐ Vomiting
☐ Difficulty Swallowing	☐ Sleep Problems	☐ Black Stools	☐ Constipation
☐ Loss of Control of Bowels		☐ Loss of Control of Urine	
☐ 2 or more falls in the last year or one fall with injuries			