

Pain Relief Centers

Return to Wellness

6640 – 78th Avenue North, Suite A, Pinellas Park, Florida 33781

Ph # (727) 518-8660 Fax # (727) 518-8662

PATIENT HISTORY FORM

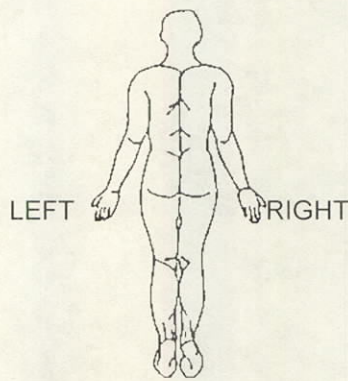
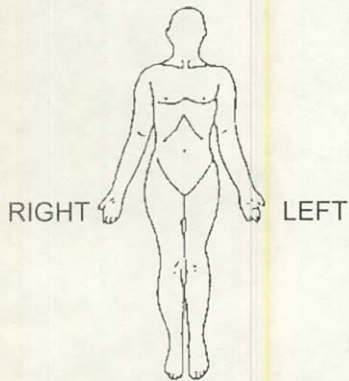
To help us understand your problem, please complete **ALL QUESTIONS** on **ALL** the attached forms prior to your visit. **If these forms are not completed before your appointment, you will be rescheduled to allow you time for completion.**

Name _____ Age _____ Date _____

Who referred you to us? _____

How long have you had this pain? _____

Please shade in the areas on the diagrams where your present pain is located.



Please circle appropriate words that best describe your pain.

- | | | | |
|----------|----------|--------------|--------------|
| ACHING | TINGLING | SURPERFICIAL | CONSTANT |
| BURNING | HOTNESS | TIGHT | INTERMITTENT |
| CRAMPING | COLDNESS | HEAVY | ANNOYING |
| NUMBING | SORENESS | INTENSE | SEVERE |
| STINGING | SHARP | BRIEF | UNBEARABLE |
| STABBING | DULL | TRANSIENT | EXCRUCIATING |
| SHOOTING | DEEP | THROBBING | SPASMS |

If "0" represents no pain and "10" represents the **WORST** pain you have ever had, circle the number that best describes the average pain you have had over the past seven days.

0 1 2 3 4 5 6 7 8 9 10

Circle Yes or No

Pain caused from: Accident – Yes or No Illness – Yes or No Unknown cause – Yes or No

If accident or illness explain and give dates:

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Please indicate if the following **increases, decreases** or causes **no change** in your **pain**.

	Increase	Decrease	No Change		Increase	Decrease	No Change
Liquor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stimulant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distraction (TV etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weather Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bright Lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loud Noises			<input type="checkbox"/>
Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep/Rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS: _____

Please **check** (✓) any of the following treatments you have had for this pain problem.

	Approximate Date/Details	Improved Pain?	
		Yes	No
<input type="checkbox"/> Pain Clinic	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nerve Blocks, Epidurals	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tens Unit	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acupuncture	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chiropractor	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Psychiatrist, Psychologist	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypnosis, Biofeedback	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	_____	<input type="checkbox"/>	<input type="checkbox"/>

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Please **check** (✓) any diagnostic procedures (tests) you have had for this pain problem.

	Body Part	Approximate Date	Facility Performed
<input type="checkbox"/> MRI Scan	_____	_____	_____
<input type="checkbox"/> CT Myelogram	_____	_____	_____
<input type="checkbox"/> X-Ray	_____	_____	_____
<input type="checkbox"/> EMG/NCS	_____	_____	_____
<input type="checkbox"/> Discogram	_____	_____	_____
<input type="checkbox"/> Bone Scan	_____	_____	_____

Please list **other physicians** you have seen for your pain:

Name	Recommendation	Specialty	Appt Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family Physician (Name and Phone) _____

Do you have or have you ever had (please check):

Heart Disease

- High Blood Pressure
- Low Blood Pressure
- Heart Murmur
- Mitral Valve Prolapse
- Chest Pain or Angina
- Irregular Rhythm
- Skipped Beats
- Heart Failure
- Heart Attack
- Pacemaker
- Easily Fatigued

Other

- Recent Weight Loss
- Recent Weight Gain
- Fever/ Chills
- Visual Change
- Hearing Change
- Snoring
- Use CPAP/BIPAP

Lung Disease

- Shortness of Breath
- Chronic Cough
- Emphysema
- Bronchitis
- T.B.
- Asthma
- O₂ Dependent (Oxygen)
- Sleep Apnea

Neurological Disease

- Epilepsy or Seizures
- Paralysis
- Dizziness
- Fainting
- Numbness
- Headache
- Concussion
- Muscle Disorder
- Stroke

Genitourinary

- Change in Bowel Control
- Change in Bladder Control
- Kidney

Gastrointestinal

- Heart Burn
- Bloody Stools
- Dark Stools
- Recent Vomit/Diarrhea
- Cirrhosis/Liver Disease
- Ulcer
- Hiatal Hernia
- Hepatitis Type _____

Immunological

- Lupus
- HIV +
- Other: _____

Muscle or Joint Disease

- Unusual Muscle Weakness
- Arthritis or Joint Disease
- Frequent Muscle Spasms
- Back Problems
- Neck Problems

Hematologic

- Anemia
- Easy Bleeding
- Poor Blood Clotting
- Sickle Cell
- Other: _____

Metabolic

- Thyroid
- Diabetes
- Other: _____

Please list any other past or current medical problems not listed: _____

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Please List any Surgeries

Surgery	Approximate Date
_____	_____
_____	_____
_____	_____

List any allergies to medications and your reaction

Medication	Dosage	Times/Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever taken or been given:	YES	NO	When/Any Problems
Anticoagulants (blood thinners-Coumadin, Heparin)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cortisone or Steroids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anesthetic (Given by a doctor or dentist)	<input type="checkbox"/>	<input type="checkbox"/>	_____

(Females please complete) _____

Date and result of last Mammogram _____ Breast Biopsy Yes No If yes, date and result _____

Could you be pregnant? Yes No Unsure Are you trying to become pregnant? Yes No

History of Number of pregnancies _____ Comments: _____

Date of last Menstrual Period _____ History of irregular vaginal bleeding? Yes No

(Males please complete) _____

Do you have difficulty Urinating? Yes No Date/result of last Chest xray _____

Date Last Rectal Prostate Exam _____ Normal? Yes No Last PSA(Prostate Blood Test)Date _____ Result _____

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Please answer the following questions:

Date/ result last colonoscopy Yes _____ Never Brain Scan (CT or MRI) Yes Date _____ Never

Have you ever had a blood transfusion? Yes No Date _____

Have you been tested for HIV Virus? Yes No Date _____ Negative Positive

Cancer History

Have you ever had cancer? No Yes What Type? _____

Approximate date of discovery _____ Treating Physician _____

Currently receiving treatments? No Yes What type? _____

Last Staging _____ Is your treating physician aware of your current pain problems? Yes No

Mental Health

Have you ever been treated for depression or any other mental health issue? Yes No

Please explain _____

Treating Physician's Name _____ Phone Number of Physician _____

Last Visit _____ Frequency of Visits _____

Origin of Depression _____

Family History

Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc.

	Age	Alive	Deceased	Medical History or Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____

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Social History

Marital Status _____ Children's Ages _____

Smoker? Yes No If you quit, when? _____

How many cigarettes did you/do you smoke per day? _____ Number of years? _____

Number of caffeinated beverages a day? (average) _____

Alcohol Use? No Yes How much? _____ Do you have a history of alcoholism? Yes No

History of street drug use? No Yes _____

Family history of drug or alcohol abuse? No Yes _____

Education History (Please check which apply)

GED High School Diploma Technical Training Undergraduate Graduate Major: _____

Work History

Presently Working: Yes No Retired Hours per Week: _____

Current/ Previous Occupation: _____ Employer: _____

Do you have any current work restrictions? Yes No If yes, describe _____

If you are not working due to your pain, when did you last work? _____

Have you been disabled by another physician? Yes No If so please explain _____

Have you been placed at Maximum Medical Improvement (MMI)? Yes No

If yes what percentage? _____ Is there an attorney involved because of your pain condition? Yes No

If yes, give name and phone number of attorney: _____

Is there a law suit or any other legal issues pending? Yes No Disability pending? Yes No

Have you had any other previous work comp injuries or claims?

Please add any additional information that you think may be helpful to us.

Signature of Patient: _____

Date: _____