

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

Date of Service: \_\_\_/\_\_\_/\_\_\_

**INTEGRATIVE PAIN CENTER OF ARIZONA**

**520-797-7246**

**PATIENT HISTORY**

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*Please have your History Form completed PRIOR to your visit. Your appointment may be rescheduled if the form is not completed.*

***Patient:***

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_

Reason for today's visit: \_\_\_\_\_

Primary Care Physician (PCP) \_\_\_\_\_

Referring Physician (RP) *Complete only if different from PCP* \_\_\_\_\_

Please list other physician specialists you have seen for pain in the last five years?

***Work History:***

Do you work? Yes  No  Are you on disability?  Yes  No

If you are currently employed please complete the following:

Employer: \_\_\_\_\_

What is your job? \_\_\_\_\_

Did an injury cause your pain?  Yes  No

If yes, how long has the pain bothered you and describe the injury. Please also list the date of the injury including year.

Date: \_\_\_/\_\_\_/\_\_\_ Length of pain \_\_\_\_\_

Describe Injury: \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

What other medical problems do you have?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Do you have any allergies?  Yes  No If yes, please list your allergy and reaction.

Allergy	Reaction	
_____	_____	<b>Iodine</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<b>Tape</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<b>X-Ray</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	

**Social History:**

Marital Status:  Single  Divorced  Married Who lives with you? \_\_\_\_\_

Do you smoke?  Yes  No How many packs per day? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you drink alcohol?  Yes  No Daily?  Yes  No # of drinks per sitting? \_\_\_\_\_

Have you ever had any problems with misuse of prescription medications, alcohol, street drugs or any other substances?  Yes  No

**Family History:**

Do you have a family history of any medical problems?  Yes  No

If yes, what? \_\_\_\_\_

Are your parents living? Mother  Yes  No Father  Yes  No

If no, age and cause of death: \_\_\_\_\_

Circle *all* words that describe your pain. (*Circle more than one, if necessary*):

- |           |             |                 |
|-----------|-------------|-----------------|
| Aching    | Sharp       | Exhausting      |
| Throbbing | Tender      | Tiring          |
| Shooting  | Hot-Burning | Sickening       |
| Stabbing  | Cramping    | Fearful         |
| Gnawing   | Heavy       | Punishing-Cruel |
|           | Splitting   |                 |

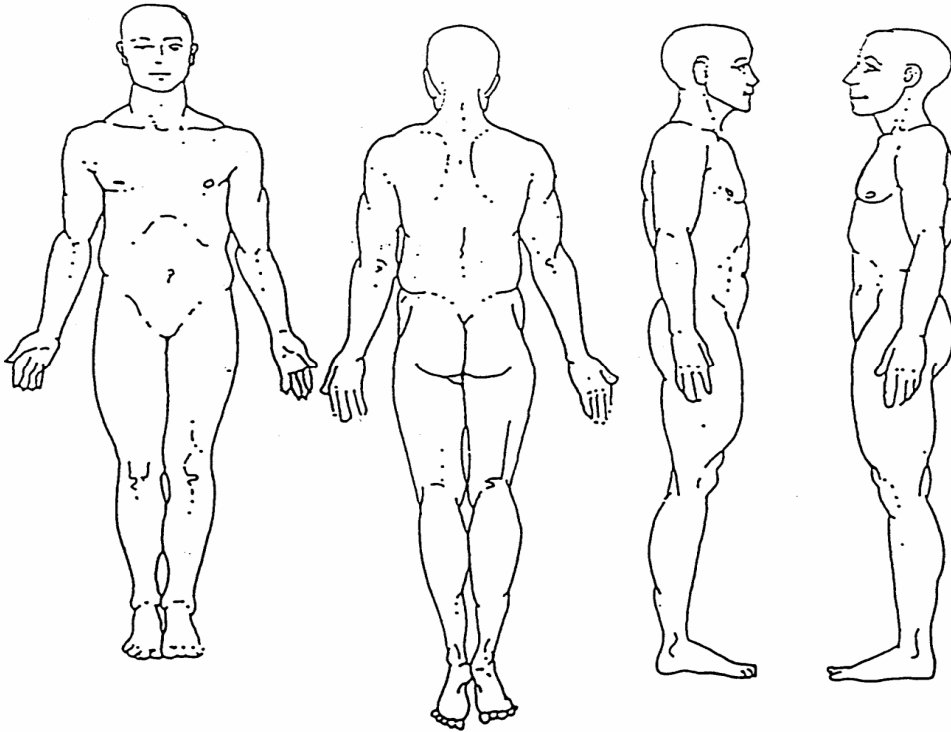
Other (please list): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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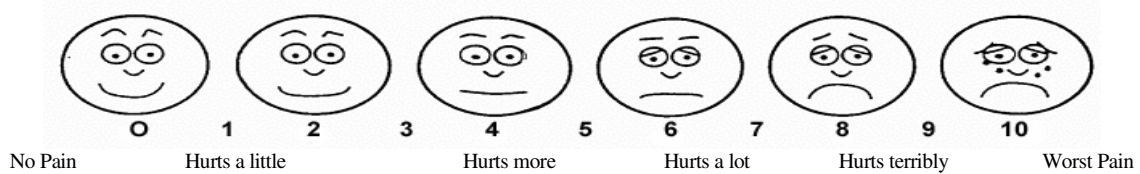
Please fill in the pain diagram below to show us where your pain is. Mark the areas below with “O”s for severe and “X”s where your pain is the worst.



**Pain Scale Instructions:**

Pain is a *subjective* experience. Please use this scale to help us understand the severity of your pain. (Circle one)

- 1-4 Pain that does not prevent you from participating and completing daily activities.
- 5 Pain that makes you feel you need medication, but does not force you to stop your activity.
- 6-7 Pain that is severe enough to stop any task and necessitates immediate medication.
- 8-9 Pain so severe and debilitating that someone else has to get your medications for you.
- 10 Absolutely the worst pain. You are completely disabled.



Which face/number shows how much you hurt **now**? \_\_\_\_\_  
Which face/number best describes your pain at its **worst** in the last 24 hrs? \_\_\_\_\_  
Which face/number best describes your pain at its **least** in the last 24 hrs? \_\_\_\_\_  
Which face/number best describes how much you hurt on **average**? \_\_\_\_\_

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Circle the *one* number in each category that best describes how, during the past 24hrs, pain has interfered with your:

**A. General Activity:**

0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely Interferes

**B. Mood:**

0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely Interferes

**C. Walking Ability:**

0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely Interferes

**D. Normal Work (include both work outside the home and housework)**

0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely Interferes

**E. Relations with other people:**

0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely Interferes

**F. Sleep:**

0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely Interferes

**G. Enjoyment of life:**

0 1 2 3 4 5 6 7 8 9 10  
Does not Interfere Completely Interferes

What is your goal for pain control?

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**PAIN MEDICATION SIDE EFFECTS:**

The following *effects* can occur in people taking pain medication. If you **are now** having any of these from your medication, place an “X” next to the level of intensity: **Mild, Moderate, or Severe.**

Nausea.....€Mild €Moderate €Severe

Poor Sex Drive..... €Mild €Moderate €Severe

Itching.....€Mild €Moderate €Severe

Sweats.....€Mild €Moderate €Severe

Rash.....€Mild €Moderate €Severe

Constipation.....€Mild €Moderate €Severe

Flushing.....€Mild €Moderate €Severe

New Headache.....€Mild €Moderate €Severe

Sweating.....€Mild €Moderate €Severe

Increase Joint Pain.....€Mild €Moderate €Severe

Feeling drunk.....€Mild €Moderate €Severe

Difficulty Urinating.....€Mild €Moderate €Severe

Dizziness.....€Mild €Moderate €Severe

Shakiness.....€Mild €Moderate €Severe

Poor Concentration.....€Mild €Moderate €Severe

Increase Tiredness.....€Mild €Moderate €Severe

New/Increase of leg/foot swelling...€Mild €Moderate €Severe

**FOR PEOPLE USING THE DURAGESIC PATCH:**

Skin irritation at the site of the medication patch.....€Mild €Moderate €Severe

Medication patches do not stick well.....€Mild €Moderate €Severe