

**Atrium Medical Center
Advanced Pain Treatment and Evaluation Center
History and Physical/ Consult**

Patient Name: _____
Date: _____
Phone: Home _____ Work _____ Cell. _____
Referred by: _____ Primary Care M.D. _____
Occupation: _____

Pain History:

Where is your pain? (specifically) _____

Does it radiate anywhere? _____

When did it begin? _____

How did it begin? _____

Was there an accident, injury or event which caused it? _____

Has your pain changed recently? _____

Do you have a pending lawsuit? -Yes - No

Pain description: How would you describe your pain? (check as many as apply)

- Sharp - Aching - Hot/burning - Electrical - Fearful
 - Throbbing - Cramping - Crushing - Splitting - Punishing/Cruel
 - Shooting - Stabbing - Heavy - Tender

Intensity: on a scale from 0 to 10 (0 = no pain, 10 = worst imaginable pain)

Rate your pain: Today _____; At its worst _____; At its best _____; On Average _____

What makes you pain better?

- resting - sitting - standing - walking - heat - ice - medication

- other: _____

What makes you pain Worse?

- sitting - standing - walking - bending - lifting - arching - twisting

- other: _____

What medications do you take for pain? (list all with doses) _____

What physician prescribes your pain medication? _____

Do you have numbness? Yes No If yes where? _____

Do you have weakness? Yes No If yes where? _____

Have you had a recent problem with bowel or bladder function? Yes No

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Patient Name: _____

Previous Treatments:

Who has treated your pain so far: _____

What treatments have been tried so far: (please check as many as apply)
If checked, when was the treatment and what was the outcome?

- | | |
|--|---|
| <input type="checkbox"/> Physical Therapy: _____ | <input type="checkbox"/> Pain Blocks: _____ |
| <input type="checkbox"/> Surgery: _____ | <input type="checkbox"/> Behavioral: _____ |
| <input type="checkbox"/> Chiropractic: _____ | <input type="checkbox"/> Psychiatric: _____ |
| <input type="checkbox"/> TENS: _____ | <input type="checkbox"/> Other: _____ |

Testing:

- | | | |
|--|--|--|
| <input type="checkbox"/> MRI Date: _____ | <input type="checkbox"/> CT Scan Date: _____ | <input type="checkbox"/> Myelogram Date: _____ |
| <input type="checkbox"/> Bone Scan Date: _____ | <input type="checkbox"/> EMG Date: _____ | <input type="checkbox"/> Discogram Date: _____ |
| <input type="checkbox"/> Other: _____ | | |

Medical History:

Please list all medication allergies and the reaction you had to the medications:

Allergies	Reaction	Allergies	Reaction

List all medications you take with the doses (include herbal preparations, diet pills, over-the-counter medications) _____

Blood Thinners: Coumadin Plavix Lovenox Heparin Aspirin Aggrenox

Past surgeries and hospitalizations: (list)

Past Medical History:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Psychiatric/Emotional | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach Disorders | <input type="checkbox"/> Bowel Disease |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Seizures | <input type="checkbox"/> Infections/Sepsis | <input type="checkbox"/> Pregnancy: |