Shirley Ryan Abilitylab

Pain Management Center

Personal Health History

Please complete all of the following information as completely as possible. This information is very important for understanding your pain problem fully, and for determining an accurate diagnosis and treatment plan. This form must be completed before we can evaluate you. Make sure you bring the completed form with you on the day of your first visit, or you will be asked to complete this form at that time before you are seen. If you have any questions, please call (312) – 238-7800.

Patient's Name:_____Date:_____

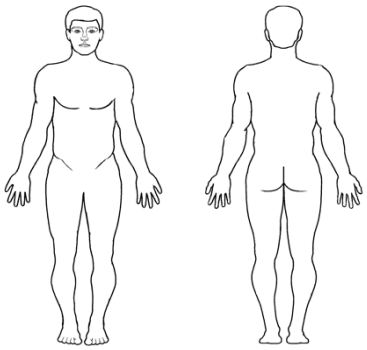
Date of Birth:_____Age:_____Best Contact Phone #:_____

CHIEF COMPLAINT (Check all that apply):

[ ] Neck Pain; [ ] Upper Back Pain; [ ] Lower Back Pain; [ ] Right Leg Pain; [ ] Left Leg Pain;

[ ] Right Arm Pain ; [ ] Left Arm Pain ; [ ] Abdominal Pain; [ ] Pelvic Pain; [ ] Headache; [ ] Other: _____

On the drawings below, please shade the area where you currently experience pain.



Please describe when and how your pain began?

_____

_____

_____

_____

_____

_____

Circle the appropriate responses:

Is there numbness present? Yes or No

If Yes, where? _____

Is there weakness present? Yes or No

If yes, where? _____

Circle the appropriate responses:

Did the pain start: Suddenly or Gradually

Was there a specific event that started the pain? Yes or No

If yes, please describe: _____

Is your pain: Stable Improving Worsening Unchanged

Does the pain radiate to any other locations? **Yes** **or** **No**

If Yes, where? _____

Below on the left side are listed several words that people often use to describe their pain. Please think about any pain you are experiencing NOW, and for each of the pain descriptors (e.g. Throbbing, etc.), place a check (√) under ONE of the four columns listed (None, Mild, Moderate, Severe) to indicate how much you are experiencing each of these sensations at this moment.

Remember: Check (√) one of the four columns for EVERY pain descriptor.

	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-cruel				

Please rate the intensity of your pain on a scale of 0 (no pain) to 10 (worst pain imaginable).

1. **Your pain right now:**
   0 1 2 3 4 5 6 7 8 9 10

2. **Your pain at its least:**
   0 1 2 3 4 5 6 7 8 9 10

3. **Your pain at its worst:**
   0 1 2 3 4 5 6 7 8 9 10

4. **Average pain this week:**
   0 1 2 3 4 5 6 7 8 9 10

What is the <u>current</u> unpleasantness of your pain from 0 (not at all unpleasant) to 10 (the most unpleasant imaginable)?
0 1 2 3 4 5 6 7 8 9 10

Circle ALL the appropriate responses:

What makes your pain worse? Bending over, Lifting, Walking, Stairs
Prolonged Sitting, Prolonged Standing, Stretching, Looking up, Looking down
Inactivity, Overhead Activity, Turning head left, Turning head right
Other: _____

What makes your pain better? Cervical pillow, Cold application, Heat application
Medication, Soft collar, Physical Therapy, Position changes
Other: _____

Have you had any of the following associated with your pain? Fever, Chills
Weight loss, Fecal Incontinence, Urinary Incontinence, Loss of Motion
Muscle weakness, Numbness, Dizziness, Visual Changes
Swelling, Joint Stiffness, Other: _____

What is the current pattern to your pain? Constant or Intermittent?
Recurrent or Chronic?
At rest or During exertion?

The pain effects your ability to: Walk Perform household functions
Perform Sexual Activities Sleep Work Attend school
Participate in Sports Run Drive
Other: _____

Which of these health care providers have you seen for treatment? Primary Care Physician
Acupuncturist Chiropractor Neurologist ED Physician
Neurosurgeon Orthopedic Surgeon Physical Therapist Physiatrist
Anesthesiologist Rheumatologist Psychologist Psychiatrist
Occupational Therapist Massage Therapist Other: _____

Which of these tests have you had to assess your pain? X-rays MRI EMG
Bone Scan SPECT CT Scan Discogram Ultrasound

Which of these treatments have you previously had done? PT Chiropractic
Pain Meds Anti-inflammatory Meds Injections Acupuncture
Massage Therapy Surgery Other: _____

What are you hoping to accomplish at today's visit? _____

I am currently having problems with my: Pain Mood
Pain medication effectiveness Physical Functioning Ability to cope with pain
Ability to manage pain flare-ups Sleep

Sleep:
Please respond to each item by marking one box per row:

In the past 7 days . . .

	Not at all	A little bit	Somewhat	Quite a bit	Very much
My sleep was restless . . .					
I was satisfied with my sleep . . .					
My sleep was refreshing . . .					
I had difficulty falling asleep . . .					

In the past 7 days . . .

	Never	Rarely	Sometimes	Often	Always
I had trouble staying asleep . . .					
I had trouble sleeping . . .					
I got enough sleep . . .					

In the past 7 days . . .

	Very poor	Poor	Fair	Good	Very good
My sleep quality was . . .					

Do you experience any of the following? Depression Anger Anxiety
Catastrophizing Apathy Fear Avoidance
Inability to experience pleasure Irritability Other: _____

Do you currently see: Psychiatrist Psychologist Social worker Other: _____
Have you previously been hospitalized due to psychological issues? Yes No
If YES, when: _____
Have you previously had any suicide attempts? Yes No
Do you currently have any thoughts of harming yourself? Yes No

REVIEW OF SYSTEMS:

Please mark all of the following that apply to you currently:

Constitutional
- [ ] Fever
- [ ] Chills
- [ ] Sweats
- [ ] Fatigue
- [ ] Recent weight gain
- [ ] Recent weight loss
- [ ] Other:_____
- [ ] Decreased activity
- [ ] Night sweats

Eyes
- [ ] Recent visual problems
- [ ] Blurred vision
- [ ] Double vision
- [ ] Other:

_____

Ears, Nose, Mouth, Throat
- [ ] trouble swallowing
- [ ] Sore throat
- [ ] Ringing in ears
- [ ] Room spinning
- [ ] Other:

_____
- [ ] Sinus drainage

Respiratory
- [ ] Shortness of breath
- [ ] Cough
- [ ] Coughing up sputum
- [ ] Wheezing
- [ ] Other:

_____

Cardiovascular
- [ ] Chest pain
- [ ] Palpitations
- [ ] Heart beating too slow
- [ ] Heart beating too fast
- [ ] Leg swelling
- [ ] Syncopal episodes
- [ ] Other:

Gastrointestinal
- [ ] Nausea
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Heartburn
- [ ] Abdominal pain
- [ ] Throwing up blood
- [ ] Rectal pain
- [ ] Other: _____
- [ ] Bloody stools

Genitourinary
- [ ] painful urination
- [ ] Pelvic pain
- [ ] Urinary frequency
- [ ] Urinary incontinence
- [ ] Urinary urgency
- [ ] Urinary retention
- [ ] Intermittent cath program
- [ ] Indwelling catheter
- [ ] Other: _____
- [ ] kidney problems

Hematologic/Lymphatic
- [ ] Easy bruising
- [ ] Easy bleeding
- [ ] Recent bruising
- [ ] Recent hemorrhages
- [ ] Petechiae
- [ ] Swollen lymph glands
- [ ] Other: _____
- [ ] anemia
- [ ] HIV +
- [ ] hepatitis

Endocrine
- [ ] Cold intolerance
- [ ] Change in hair texture
- [ ] Hyperglycemia
- [ ] Hypoglycemia
- [ ] Other: _____
- [ ] thyroid (too little)
- [ ] thyroid (too much)
- [ ] low testosterone

Musculoskeletal
- [ ] Back pain
- [ ] Neck pain
- [ ] Joint pain
- [ ] Muscle pain
- [ ] Muscle spasms
- [ ] Muscle weakness
- [ ] Decreased ROM
- [ ] Trauma
- [ ] Other:

_____
- [ ] gout
- [ ] osteoporosis

Integumentary (Skin)
- [ ] Skin Rash
- [ ] Itching
- [ ] Abrasions
- [ ] Skin Breakdown
- [ ] Burns
- [ ] Dryness
- [ ] Petechiae
- [ ] Skin

Neurological
- [ ] Numbness
- [ ] Tingling
- [ ] Dizziness
- [ ] Headache
- [ ] Loss of Coordination
- [ ] Memory problems
- [ ] Loss of muscle tone
- [ ] Spasticity
- [ ] epilepsy (seizures)
- [ ] Weakness
- [ ] Dystonia
- [ ] Other:

_____

Psychiatric
- [ ] anxiety
- [ ] depression
- [ ] Attention disorder
- [ ] Irritability
- [ ] Sleeping problems
- [ ] Other:

_____

Do you have any of these medical diseases?

[ ] Rheumatoid Arthritis
[ ] Coronary Artery Disease
[ ] Heart problems
[ ] Kidney problems
[ ] Lung problems
[ ] Epilepsy (seizures)
[ ] Thyroid problems
[ ] Neurologic disorder
[ ] Cancer: Type: _____
[ ] High blood pressure
[ ] Diabetes
[ ] Stomach ulcers
[ ] Gout
[ ] Stroke
[ ] Anemia
[ ] Other – Specify: _____

Do any of your blood relatives have any of these medical diseases?

[ ] Back or Neck Problems
[ ] Rheumatoid Arthritis
[ ] Coronary Artery Disease
[ ] Heart problems
[ ] Kidney problems
[ ] Lung problems
[ ] Epilepsy (seizures)
[ ] Thyroid problems
[ ] Neurologic disorders
[ ] Rheumatologic disorders
[ ] Cancer: Type: _____
[ ] High blood pressure
[ ] Diabetes
[ ] Stomach ulcers
[ ] Gout
[ ] Stroke
[ ] Anemia
[ ] Other – Specify_____

Please List all prior surgeries:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

SOCIAL HISTORY:

How often do you use alcohol? Never Occasional Regularly Previous Abuse
How many drinks do you have per week? _____ Beer Wine Hard Alcohol

How often do you smoke? Never Occasional Regularly Previously Smoked
How many: **Packs per day?** _____ **Number of years?** _____

Within the last two years have you used any illegal drugs? None Occasional Regularly
If so, what kind? Amphetamines Cocaine Ecstasy Heroin
Inhalants LSD Marijuana Methamphetamines PCP

Have you ever had a problem or been told that you had a problem with alcohol, recreational drugs or medication overuse? Yes or No

Are you: Married Single Divorced Separated Widowed Partner
Living Situation: House or Apartment
Number of levels? _____Number of stairs to enter? _____ **Number of stairs inside? _____**
How often do you regularly exercise? Never Occasional Regularly
What type of exercise? _____
What do you do during the day? _____
_____
How often do you drive? Never Occasional Regularly

Which of the following best describes your highest level of education:

Less than high school High school diploma or GED Community/junior college or vocational training
Bachelor's degree Advanced degree (master's or doctorate)

OCCUPATIONAL HISTORY

Are you currently:

Employed Full-time	Employed Part-time	Not working
Unemployed	Disabled	On Disability
Retired	Student	Other: _____

When did you last work? _____

What type of work do you or did you do? _____

Are you currently receiving worker's compensation benefits? Yes or No

Are you currently involved in a lawsuit concerning your injuries? Yes or No

ALLERGIES:

Please list all allergies: _____ _____

_____ _____ _____

FOR FEMALES ONLY:

Are you currently pregnant? Yes No

Are you currently lactating and/or Breast Feeding? Yes No

MEDICATIONS:

Please list all medications (prescription and nonprescription) and doses that you now take:

Medication	Dose & Frequency	How long on it

Are your medications for pain less effective than they used to be? Yes or No

Have you had to increase your pain medications to get the same effect? Yes or No

Please list meds previously tried: _____ _____

_____ _____ _____

_____ _____ _____

Please list your **current pharmacy** that you wish for us to use for electronic prescriptions:

_____

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Signature_____ Please Print_____

Date _____