



Pain Assessment/Medical History Form

Patient Name: _____

Have you had or do you have any of the following:

- | | | | | | |
|------------------------|---|---|------------------------|---|---|
| 1. Cancer | Y | N | 9. Metal Implants | Y | N |
| 2. Heart Disease | Y | N | 10. Respiratory Prob. | Y | N |
| 3. Pacemaker | Y | N | 11. Smoking | Y | N |
| 4. High Blood Pressure | Y | N | 12. Hernia | Y | N |
| 5. Diabetes | Y | N | 13. Frequent Headaches | Y | N |
| 6. Seizure Disorder | Y | N | 14. Fractures | Y | N |
| 7. Head Injury | Y | N | 15. Stroke | Y | N |
| 8. Arthritis | Y | N | 16. Are you pregnant | Y | N |
| | | | 17. Allergies | Y | N |

Date of injury: _____

Date of surgery: _____

Occupation: _____ Full time Light duty Off work Retired

Previous Injuries: _____

Current Medications: _____

Perceived Pain: (At rest) 1 2 3 4 5 6 7 8 9 10 (After activity) 1 2 3 4 5 6 7 8 9 10
*(0 is no pain; 10 is emergency room)

Check what limitations apply: Decreased sitting/standing Decreased walking
 Decreased work/recreational activities Decreased activities of daily living
 Decreased sleep Other _____

Pain Type: Radiating Shooting Burning Tingling Stinging

Aggravating Factors: _____

Relieving Factors: _____

Patient Signature: _____