Comprehensive Spine & Pain Center of New York

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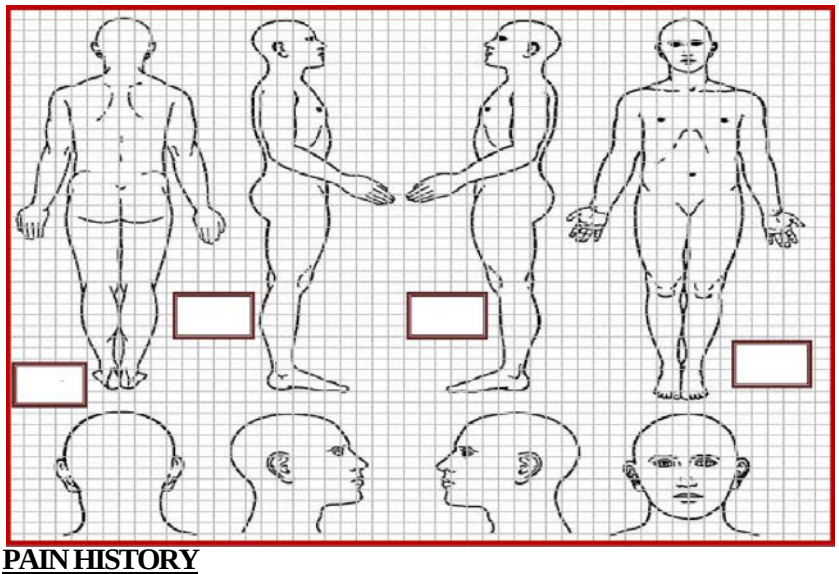
Name:_____Date: _____

Date of Birth:_____Age:_____

Please mark/shade on the picture below where your pain is located and where it travels:



PAIN HISTORY

1. WHEN did your pain begin? (Please be as specific as possible - for example: "4 months ago")

2. How did your pain begin? (Please check one and describe below)

__Pain Just Started By Itself
__Injury or Accident At Work
__Injury or Accident At Home
__ Motor Vehicle Accident – **date of accident** _____
__ Other Reason (specify):

3. WHAT DOES YOUR PAIN FEEL LIKE? Please circle:

1	2	3	4
Sharp	Dull	Annoying	Penetrating
Burning	Aching	Miserable	Piercing
Electricity	Sore	Intense	Tight
Shooting	Hurting	Unbearable	Numb
Stabbing	Heavy	Troublesome	Squeezing
Lancinating	Tender	None	Cool
Tingling	Tiring		Cold
Throbbing	Sickening		Nauseating
Pounding	Terrifying		Agonizing
Cramping	Punishing		Dreadful
Crushing	Blinding		Torturing
Pulling			

4. Circle all that apply - Is you pain…
Constant intermittent improving worsening

5. Circle which activities or body positions bring on or WORSEN YOUR PAIN? – Sitting, standing, walking, laying down, daily activities, lifting, Coughing/Sneezing, Hot/Cold Weather, Damp Weather, Bowel Movement, Exercise, Other(write in):

_____

Circle which activities or body positions seem to IMPROVE YOUR PAIN - Sitting, standing, walking, laying down, Bed Rest, Chiropractor, Physical Therapy, Heat/Cold, Relaxation Training, Medications, Exercise Program, Acupuncture, Massage Therapy, Biofeedback, Injections or other (write in)

_____

6. Associated symptoms (check <u>all</u> that apply):
__ weakness of the arm(s)
__ weakness of the leg(s)
__ numbness in the arm(s)
__ numbness in the leg(s)
__ loss of bladder or bowel control
__ cool, pale skin
__ skin color changes
__ difficulty sleeping
__ fever
__ weight loss
__ OTHER: _____

7. Which TREATMENTS have you had for your pain (check all that apply)

	Helpful?	When was this done?
__Pain killers	Yes/No	_____
__Anti-inflammatory meds	Yes/No	_____
__Muscle relaxants	Yes/No	_____
__Physical or chiropractic therapy	Yes/No	_____
__Cortisone shots	Yes/No	_____
__Epidural injections	Yes/No	_____
__Other (describe)	Yes/No	_____

8. List any medications you have taken in the past which did NOT help:

PAST MEDICAL & SURGICAL HISTORY:

12. **Have you ever been diagnosed with or treated for any of the following health problems? (Please check and circle all items that apply)**

__ Angina / Chest Pain
__ Angioplasty or Stent for blocked artery
__ Anxiety, Depression, or Panic Disorder
__ Arrhythmia/Atrial Fibrillation /Cardiac Arrest
__ Arthritis (Type?: Osteo / Rheumatoid)
__ Asthma / Wheezing
__ Bipolar Disorder
__ Bleeding Disorder (Hemophilia, ITP, etc.)
__ Cancer (Type _____)
__ Chronic Cough
__ Congestive Heart Failure (year? _____)
__ Deep Venous Thrombosis (Blood Clot Leg)
__ Diabetes (__ Type I __ Type II)
__ Drug or Alcohol Abuse / Addiction
__ Emphysema, Chronic Bronchitis, or COPD
__ Fibromyalgia
__ Headache (Migraine, Cluster, or Tension ?)
__ Heart Attack (year? _____)
__ Hepatitis (Circle Type: A / B / C)
__ High Blood Pressure
__ HIV or AIDS
__ Implantable Defibrillator
__ Kidney Failure / Dialysis
__ Liver Disease / Cirrhosis
__ Neuropathy (Type? _____)
__ Obesity
__ Pacemaker
__ Paralysis (Describe_____)
__ Previous Suicide Attempt
__ Pulmonary Embolism (blood clot to the lung)
__ Seizure or Epilepsy
__ Sickle Cell Disease
__ Stomach or Duodenal Ulcer (Year _____)
__ Stroke or TIA
__ Thyroid Disease (Under or Overactive?)

13. On a scale of 0-10 (0 is no pain, 10 is worst imaginable) what is your pain (circle)?
On average: 0 1 2 3 4 5 6 7 8 9 10
At its worst: 0 1 2 3 4 5 6 7 8 9 10

14. Please list any SURGICAL operation(s) you have had in the past:
Year Operation

15. Please list any DRUGS, contrast dyes, medications, foods that you are ALLERGIC to:

16. Please list all CURRENT MEDICATIONS with the doses that you are taking. List all BLOOD THINNERS*

17. SOCIAL HISTORY (check and fill in answers):

Do you smoke? [ ] Yes [ ] No [ ] Quit If yes, how much? _____ How many years? _____
Do you drink alcohol? [ ] Yes [ ] No If yes, how much? _____
Do you have any history of using Marijuana, Cocaine, Heroin, or any other illegal drugs?
[ ] Yes [ ] No If yes, which drugs? _____
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed
Occupation: _____
Work Status: [ ] Working [ ] Not working [ ] Retired [ ] Disabled [ ] Unemployed
Reason and date of disability: _____

18. What is your Height?_____ Weight:_____

Your doctor will complete the rest of this form

Physical:

Impression:

Plan:

_____ Tim Canty, M.D.