MountainStar
Lakeview Hospital
Pain Management Center

PATIENT HISTORY FORM -

Name:	Date:	Primary Care Physician:
Date of birth:	Age:	Referring Physician:
Referred for:		

Please fill out as completely as possible. This information will determine how we treat your pain problem.

WHEN did your pain start?

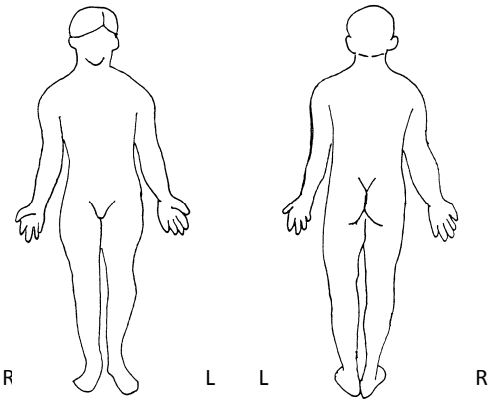
WHERE is your pain? Color the areas on this diagram.
Red: Excruciating or Severe Pain, Green: Moderate pain
Blue: Mild pain

In the last 2-3 weeks, WHEN does your pain occur?

- ☐ intermittent (on/off)
- ☐ less than 8 hours/day
- ☐ 8-16 hours/day
- ☐ constant

HOW did your pain start?

- ☐ auto accident
- ☐ work related
- ☐ after surgery
- ☐ fall (not at work)
- ☐ other, describe: _____



WHAT does your pain feel like?

- ☐ burning ☐ aching ☐ sharp
- ☐ stabbing ☐ dull ☐ cramping
- ☐ mild ☐ moderate ☐ severe
- ☐ other, describe: _____

Please indicate those activities that INCREASE your pain:

- ☐ work ☐ lying flat ☐ other, describe: _____
- ☐ walking ☐ standing
- ☐ bending ☐ sitting

Pain Score 0 = no pain, 10 = worst pain (please circle)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10

Please indicate those activities that DECREASE your pain:

- ☐ walking ☐ physical therapy
- ☐ standing ☐ relaxation
- ☐ rest ☐ lying flat
- ☐ heat ☐ bending
- ☐ cold ☐ medications
- ☐ injections ☐ emergency room treatment
- ☐ sitting ☐ not working
- ☐ other, describe: _____

Past Surgical History – on back or neck: If YES, list below:

Please list ALL current prescribed and over-the-counter medications: *medication – dose – frequency*

Does your pain affect your quality of life?
☐ YES ☐ NO

Does your pain keep you from falling asleep at night?
☐ YES ☐ NO

Does your pain awaken you at night?
☐ YES ☐ NO

Do you take anticoagulants (heparin, Coumadin, fragmin, lovenox, enoxaparin, normiflo, ardeparin, orgaran, danaparoid)?
☐ YES ☐ NO

Are you involved in a lawsuit(s)? If so, check all that apply:
☐ Worker's Compensation ☐ Auto Insurance ☐ Disability Claim
☐ Other, describe: _____

ALLERGIES – Please list all the medications you are allergic to and/or have had problems tolerating. Briefly list the specific allergy or problem which occurred.

Date:	Time:	Reviewed by:

Patient Label