Pain Specialty Consultants, P.A.
1200 Brooklyn, Suite 140, San Antonio, Texas 78212
Phone: (210) 527-1166 • Fax: (210)527-1163
www.paindoctorsa.com

Patient History Form

Personal Data (please print)

Date: _____ **Name**: _____
Birth Date: _____ **Age:** ____ **Ht**: ____ **Wt**: _____
Drivers License #_____

What is your current employment status?:
❒ Full Time ❒Part Time ❒Retired ❒Homemaker
❒ Unemployed due to pain
Date last worked: _____

Marital Status: ❒Married ❒Single
❒Divorced ❒Widowed # of times married:_____
Highest level of Education: ❒Grade School
❒ High School - Grad. Date: _____
❒Voc/Tech/Bus **Occupation:** _____
❒ College Degree_____

Have you changed your job for health reasons? ❒Yes ❒ No
What is your level of physical activity at work? ❒Highly Active ❒ Slightly Active
❒Moderately Active ❒ Inactive
Are you pregnant or is there a chance that you could be pregnant? ❒ Yes ❒ No
Have you or anyone in your family had a problem with an Anesthetic? ❒ Yes ❒ No
If yes above, please explain further_____
Are there any medical problems that run in your family? _____
Do you smoke? ❒ Yes ❒ No
Do you consume alcohol? ❒ Yes ❒ No
If you consider yourself disabled, please indicate the date of onset of your disability: _____
Sleep Pattern: _____
Do you exercise? ❒ Never ❒ Rarely ❒ Frequently Type _____
Do you have any emotional or psychological problems that concern you? ❒ Yes ❒ No
If yes above, please explain:_____
Have you ever seen a psychologist or a psychiatrist? ❒ Yes ❒ No
How many times have you been to the emergency room, because of the present pain? _____ Times
What do you want from your treatment? _____
What do you expect from your treatment? _____
If your pain cannot be helped what do you plan to do? _____
List any hobbies or special interests: _____

Health Questionnaire

Drug allergies: ❒ No ❒ Yes, Please List: _____
Current medications: what, if any, medications are you taking now. Please list all medications.

Medication	Why prescribed	Dosage	How Often	Effectiveness: Very/Not at all
1				
2				
3				
4				
5				
6				
7				

Have you ever felt you had to cut down on medication? ☐Yes ☐No
Have People annoyed you by criticizing your medication use? ☐Yes ☐No
Have you ever felt guilty about your medication use? ☐Yes ☐No
Have you ever needed an eye opener or needed medications to feel normal? ☐Yes ☐No

Personal Medical History: (Please check and explain)

❒ High Blood Pressure ❒ Diabetes ❒ Glaucoma ❒Mental Illness
❒ Abnormal Pap Smear ❒Blood Clots ❒ Peripheral Neuropathy
❒Sexually Transmitted Disease ❒ Heart Disease ❒ Cancer
❒ Seizures ❒ Fatigue ❒ Gout ❒Migraine Headaches
❒ Asthma ❒ Tuberculosis ❒Alcoholism ❒ Shortness of Breath
❒ Stroke ❒ Anemia ❒ Allergies ❒Arthritis
❒Kidney Disease ❒ Fibromyalgia ❒COPD ❒Bladder Infection
❒ Abnormal Bleeding ❒Liver Disease ❒ Sexual Dysfunction
❒ Ulcers ❒ Dizziness, Fainting ❒Osteoporosis
❒ Thyroid Disease ❒ Mononucleosis ❒Peripheral Vascular Disease
❒ Restless legs syndrome ❒Sleep Apnea ❒Connective tissue disorder
❒Other

Past surgical history: (please check all that apply)

❒Aneurysm ❒Appendix ❒Gastric Bypass ❒Gall bladder ❒Breast
❒CABG ❒Carotid ❒Carpal tunnel ❒Cesarean section ❒Cataracts
❒Hip ❒Knee ❒Hernia ❒Hysterectomy ❒Low Back Surgery
❒Cervical spine surgery ❒Pacemaker ❒Prostate ❒Tonsils ❒Urinary
❒Bladder ❒Kidney ❒Thyroid ❒Other

Other Surgeries, please explain

1.
2.
3.
4.
5.

Physician's Comments

(for office use only)

Review of systems:

Constitutional: fever, chills, night sweat, weight gain, weight loss, anorexia, fatigue
Psych: depression, aggression, anxiety, suicidal ideation
GIT: nausea, vomit, diarrhea, constipation, heartburn, melena, hematochezia, abdominal pain GU: nocturia, polyuria, polydipsia, hematuria, pyuria, incontinence
CVS: chest pain, palpitation, failure
Resp: cough, sputum, hemoptysis, SOB
Blood: bleeding dyscrasias, pallor
Skin: rash, lumps
Metabolic : polyphagia, hot, cold, obesity
Neuro: dizziness, tingling, numbness, syncope, headaches
Eyes: discharge, redness, vision

Alert Oriented: x3 HR BP RR

Mood: depressed, anxious
GPE: well developed, well nourished, well groomed
Scalp: normocehalic, nontraumatic
Eyes: Anemia, Icterus, PERRLA
Ears: no tragal tender, no discharge
Nose: septum central, mucosa pink, no polyps
Tongue: central moist, pink
Neck: supple, trachea central, no thy romegaly, no JVD
Chest: hyperresonant, CTA
Heart: S1S2, no murmur, no gallop
Abdomen: soft, nontender, no organomegaly
Extremeties: no calf tenderness, no edema, no clubbing, no cyanosis, pulses +

Current Medical Problems:

Pain History:

Describe in your own words what your pain is like (location, how it feels, is it consistent, does it come and go, do you have numbness, etc.)

_____

_____

How and when did your pain problem first start? (accident, disease, after surgery, date of onset, etc_____

_____

How much work have you missed since pain onset?_____
Do you always have pain at rest? _____

Type of pain:

❒ Sharp ❒ Dull Ache ❒ Burning ❒ Throbbing ❒ Tiring
❒ Constant ❒ Intermittent ❒ Tingling ❒ Cutting ❒ Sickening
❒ Pressing, Pulling ❒ Numb ❒ Cramping ❒ Other
❒ Punishing ❒ Stinging ❒ Stabbing ❒ Spasms ❒Fearful

Physician Comments
(Office use only)

Physician Comments
(Office use only)

Pain made worse by: ❒ Sitting ❒ Standing ❒ Walking ❒ Sneezing

❒ Coughing ❒ Straining ❒ Flexing ❒ Extension ❒ Light Stroking of Skin ❒ Other

Made better by: ❒ Rest ❒ Sitting ❒ Medication

❒ Other: _____

Time of day your pain is worse: ❒ Morning, on arising ❒ Later in morning

❒ Afternoon ❒ Evening ❒ Bedtime ❒ Night - sleeping hrs. ❒ Pain is always the same

❒ Pain varies - no particular time is worse

Have you had bowel changes: ❒ Yes ❒ No

Bladder changes: ❒ Yes ❒ No

Paralysis: ❒ Yes ❒ No

Have you noticed any of the following changes in the painful area:

❒ Increased nail growth ❒ Skin change ❒ Swelling

❒ Hair growth ❒ Sweating ❒ Goose bumps

❒ Temperature change, if so: ❒ Cold ❒ Hot

Previous Treatment for Pain:	Yes	No	Helpful	Not Helpful	Problem
Nerve Blocks					
Surgery					
TENS Unit					
Occupational/Physical Therapy					
Biofeedback					
Hypnosis					
Counseling					
Chiropractic					

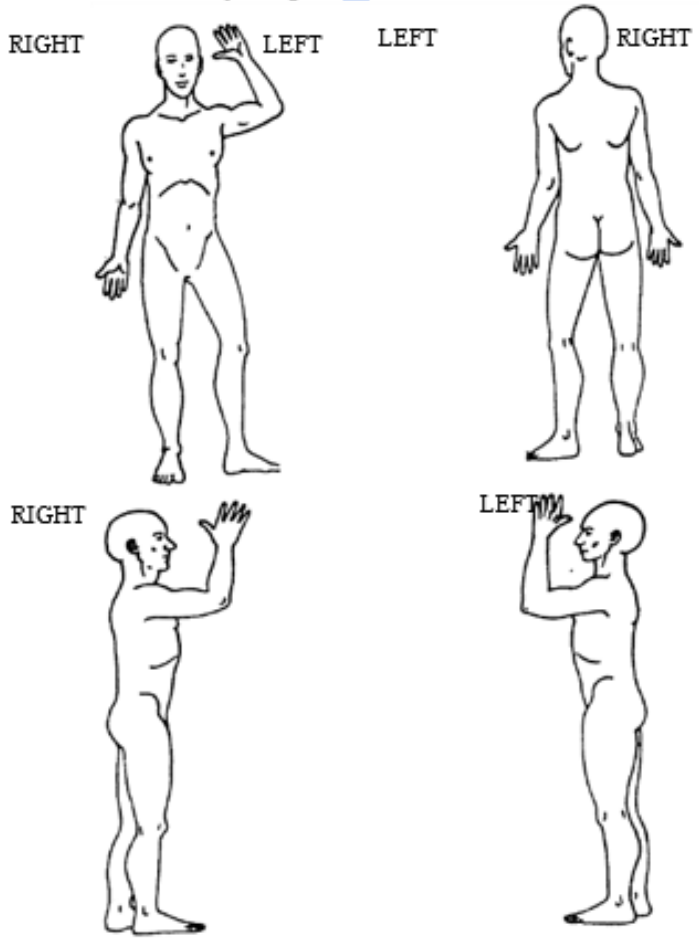
Which of the following tests have you had to evaluate your pain within the past six months to year?

Test	Date	Results
X-Ray		
Laboratory/Blood/Urine		
CT Scan		
MRI		
Other		

Name of Physicians involved in your medical care:

Physician	Address	Phone

Mark the areas of your pain: (Please complete this page)



On a scale of 0 to 10 rate your pain:

0	1	2	3	4	5	6	7	8	9	10
No Pain										**Worst Pain Imaginable**

Physician Comments

(Office use only)

Physical Exam:

Gait:
anantalgic/limp/slow/waddling/cane/
walker/wheelchair

Coordination: heel knee/shin /finger/nose

Cervical Spine: tender/ spasm/
ROM/ spurling/ distraction/
valsalva

Thoracic Spine:

Lumbar Spine: paravertebral spasm/ tender
/S.I.joint/scar/ glutealtender/ greater trochanter/ ROM

Extremities: well built/atrophy/ nontender
/tender/length equal/unequal/ spasticity pulses

FROM/Limited ROM/Phalen's (press)
Tinel's (tap)
Hips / Knee
Ankle / Foot /
Shoulder/
Elbow / Wrist

Sensory:
loss of sensation, allodynia, nail change, temp change, hair change, skin change, color, pulses, trigger points

Motor: mass, power, tone, fasciculations, involuntary movement, reflexes

C:5 motor: shoulder abduct sensory: lateral arm reflex: biceps

C:6 motor: wrist extension
sensory:lateral forearm reflex:
brachioradialis

C:7 motor: wrist flexion/finger extension sensory:
middle finger reflex: triceps

C:8 motor: finger flexion
sensory; medial forearm

T:1 motor: finger abd/add

sensory: medial arm

L:4 motor: foot inver sensory: medial leg
reflex: patellar

L:5 motor: toe exten
sensory: dorsal foot

S:1 motor: foot inver
sensory: lat foot
reflex: achilles

Misc: SLR/Patricks/Hoover/Freiburg
(pirifomis)

Head:
supraorbital/infraorbital/occipital/
auriculo temporal