M. Kathryn Schaefer, M.D. LLC

Patient Name: _____ Date: ____/____/____

Ht: _____ Wt: _____

Referring Physician: _____ Phone _____

Specialty of the Referring Physician: _____

Primary Care Physician:_____ Phone _____

PAIN INTAKE

What is the cause of your pain (ie, the diagnosis as far as you know?)

_____

_____

When and how did your pain start?

_____

_____

How has the pain changed over time?

_____

Check the words that describe your pain:

Aching	Sharp	Hot / Cold
Throbbing	Tender	Nauseating
Shooting	Burning	Sensitive
Stabbing	Exhausting	Weakness
Constant	Tingling	Gnawing
Intermittent	Numbness	Unbearable

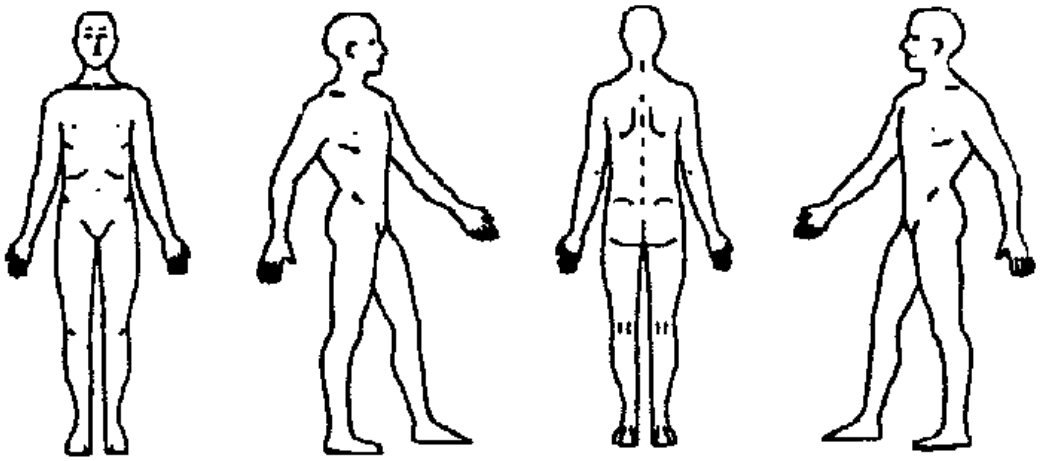
Circle the number that best describes the usual severity your pain.

0 1 2 3 4 5 6 7 8 9 10

none worst pain possible

What is your pain level today (according to the above scale)?_____

Shade in the areas where your pain is located. "X" the areas that hurt the most.



Where is the worst pain?

_____

Is the pain worse at certain times, constant, or varies?

_____

_____

What makes the pain feel **better**? (e.g. heat, rest, medicine)

_____

_____

What makes the pain feel **worse**? (e.g. walking, sitting, lifting)

_____

_____

Have you had any tests for your pain?

	Yes	No	Date
X-rays			___/___/___
MRI/ CAT scan			___/___/___
EMG/ Nerve Test			___/___/___
Myelogram			___/___/___
Bone Scan			___/___/___
Discogram			___/___/___
Other: _____			___/___/___

What treatment have you received in the past?

	No	Yes	Check if it was helpful
Physical Therapy			
Epidurals or other Nerve Blocks			
Trigger Point Injections			
Surgery			
Chronic Pain Management Programs			
Biofeedback			
Chiropractic			
Acupuncture			
TENS Unit			
Other: _____			

Allergies (include medication, food, and type of reaction): None

_____

_____

Do you take **COUMADIN** or blood thinners? Yes No

Names of current Medications used for **PAIN**: Dose How Long ?

_____

_____

_____

_____

Names of other current Medications: Dose Reason

_____

_____

_____

_____

_____

Names of Medications tried for pain in the past: Reason for discontinuing:

_____

_____

_____

PAST MEDICAL HISTORY

Check all that apply:

Diabetes	Stroke	Kidney Disease
High Blood Pressure	Asthma	Stomach/Bowel Problems

Heart Disease	Emphysema	Fainting/Dizzy Spells
Hepatitis	Psychiatric	Heart Attack/Chest Pain
Bleeding Problems	Cancer	Thyroid Disease
Arthritis	HIV +	Glaucoma
Seizures	Migraines	Infections
Past Transfusions	Anemia	Other_____

What diseases are in your family?_____

Surgeries: Type and Date

_____

_____

_____

Do you have any of the following?

Headaches		
Vision Problems	Stomach Pain or Heart Burn	Swollen Joints
Fever	Nausea/Vomiting	Muscle Cramps
Infection	Constipation	Rashes
Chest pain	Diarrhea	Sinus problem/rhinitis
Shortness of Breath	Urinary Problems	Depression
Swelling of feet	Sexual Difficulty	Weight changes

Does the pain interfere with any of the following?:

General Activities	Relations with Other People	Sleep
Walking Ability	Enjoyment of Life	Job
Climb Stairs	Ability to Concentrate	Mood
Ability to Drive	Housework	Sexual Relations

SOCIAL HISTORY

Marital Status: S M D W Children: N Y How many?_____

Disabled: N Y How long? _____

How much Exercise do you get? none minimal moderate

What kind of exercise do you do?_____

Do you use a wheelchair, walker, cane, brace, etc?_____

Smoke: No Yes Packs/day: _____

Alcohol: No Yes Type/Amount/Frequency: _____

History of Alcoholism: No Yes

Past or present use of cocaine, amphetamines, marijuana? No Yes

Is your pain workman's comp related? No Yes

Are you presently involved in a lawsuit? No Yes

List all doctors you are currently seeing or have treated you in the past:

Physician Name Phone

_____
_____
_____
_____
_____

Mahalo!