HealthEast
Pain Center
Phone: (651) 232-5354
Fax: (651) 232-5217

Name _____ Date of Birth ____/____/____Today's Date____/___/____

Primary Physician _____ Referring Physician _____

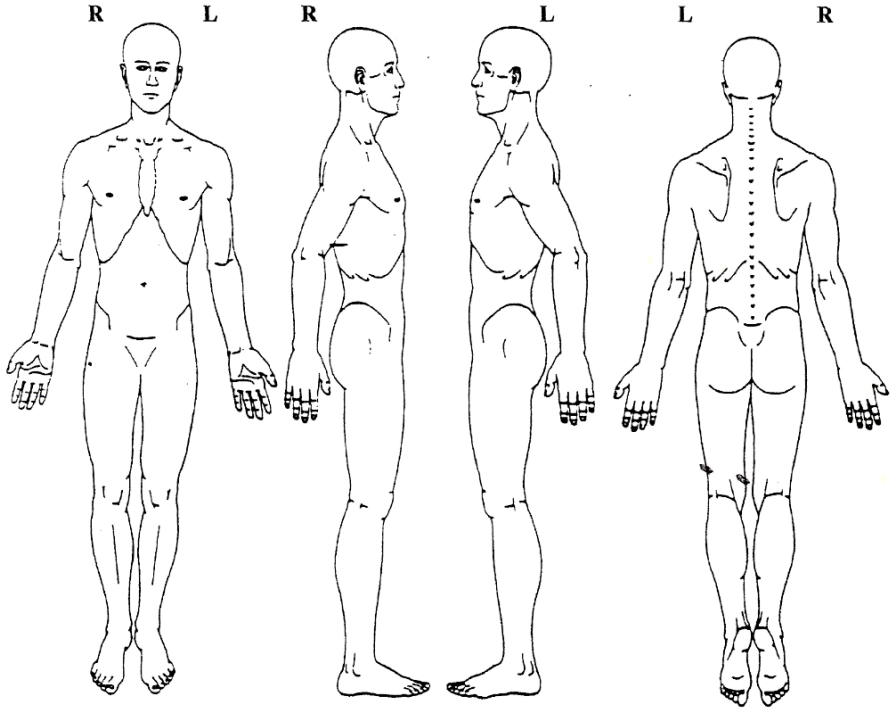
Is this work / auto accident related and date of injury? _____

Describe your current pain problem _____

How did it start / develop _____

_____

****Please circle in diagrams the location of your pain.**



Associated Symptoms-

□ Weight loss
How many pounds

_____

□ Weight gain
How many pounds

_____

□ Fever or chills

□ Rash
Location

_____

□ Swelling
Location

_____

Circle one number that best describes your average pain level.

1 2 3 4 5 6 7 8 9 10
No Pain Worst Possible Pain

Circle two numbers that best describes your lowest and highest pain level in the past week.

1 2 3 4 5 6 7 8 9 10
No Pain Worst Possible Pain

Usual Pain Intensity: □ Mild □ Moderate □ Severe

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My Pain is: □ Constant □ Intermittent □ During the day □ In the morning □ At night

My Pain Interferes With: □ Daily activities □ Sleep □ Work □ Recreational activities □ Concentrating

What Does Your Pain Feel Like ?

□ Sharp	□ Tingling	□ Diffuse	□ Cramping	□ Tender
□ Dull	□ Numbness	□ Localized	□ Throbbing	□ Swollen
□ Burning	□ Shooting	□ Deep	□ Pressure	□ Grinding
□ Aching	□ Stabbing	□ Superficial	□ Gnawing	□ Heavy

What Makes Your Pain Worse ?

□ Standing	□ Reaching	□ Bending	□ Going upstairs	□ Riding in the car
□ Sitting	□ Twisting	□ Stretching	□ Going downstairs	□ Get our of car
□ Walking	□ Lifting	□ Coughing	□ Weather Change	□ Get out of bed
□ Lying down	□ Squating	□ Sneezing	□ Eating	□ Any movement

What Makes Your Pain Better ?

□ Medications	□ Massage	□ TENS	□ Relaxation
□ Physical Therapy	□ Pressure	□ Acupuncture	□ Meditation
□ Pool Therapy	□ Heat	□ Sitting down	□ Eating
□ Sleep	□ Cold	□ Lying down	□ Nothing

Previous Diagnostics & Treatments for Pain (Please List / Describe):

Imaging (MRI, CT, x-ray, EMG): _____

Injections: _____

Surgery: _____

Physical Therapy/Occupational Therapy: _____

Pain Psychology/Counseling: _____

Chiropractor: _____

Acupuncture/Acupressure: _____

Massage: _____

Heat/Ice: _____

Bracing: _____

Exercise: _____

Meditation/Spiritual Practice: _____

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Mental Health History:

Have you been diagnosed with a mental illness (i.e. Depression, Anxiety, Bipolar) ? Please describe:

_____

Do you have a current or previous mental health provider ? Please describe:

_____

Have you had a previous hospitalization for your mental illness ? Please describe:

_____

Do you have current or previous suicidal ideation or previous suicide attempt ? Please describe:

_____

Have you ever been physically, sexually, or emotionally abused or neglected ? □ Yes □ No

_____

Are you now or have you been concerned about possible abuse or neglect in your home ? □ Yes □ No

_____

Have you ever had treatment for chemical dependency ? □ Yes □ No When _____

Current Medication List & Drug Allergies:

Medication Name	Strength (milligrams)	Instructions	Taking/Not Taking
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Please attach typed or hand written list of medications if your list exceeds the given space.

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Previously Tried Pain Medication:

Medication	Helpful	Not Helpful	Unsure	Side Effect
Acetaminophen (Tylenol)				
Ibuprofen (Motrin)				
Naproxen (Aleve)				
Celecoxib (Celebrex)				
Diclofenac (Voltaren)				
Gabapentin (Neurontin, Grailise ER, HorizantER)				
Pregabalin (Lyrica)				
Amitriptyline				
Nortriptyline				
Duloxetine (Cymbalta)				
Venlafaxine (Effexor)				
Tizanidine				
Methocarbamol (Robaxin)				
Cyclobenzaprine (Flexeril)				
Metaxalone (Skelaxin)				
Carisoprodol (Soma)				
Baclofen				
Lidoderm gel or patches				
Diclofenac gel (Voltaren gel)				
Compounded pain creams				
Codeine, Codeine/Acetaminophen (Tylenol #3)				
Hydrocodone, Hydrocodone/Acetaminophen (Hysingla ER, Zohydro ER, Vicodin, Lortab)				
Oxycodone IR, Oxycodone/Acetaminophen (Percocet)				
Oxycodone ER (Oxycontin, Xtampza ER)				
Tramadol (Ultram)				
Morphine (MS Contin, MSIR, Kadian)				
Hydromorphone (Dilaudid)				
Methadone				
Fentanyl Patch				
Buprenorphine (Butrans Patch, Belbuca)				
Tapentadol (Nucynta IR, Nucynta ER)				
Oxymorphone (Opana ER, Opana IR)				

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Drug Allergies :

Medication Name	Reaction
1.	
2.	
3.	
4.	
5.	
6.	

Past Medical History :

Aneurysm	yes / no	Diabetes	yes / no	Liver disease	yes / no
Stroke	yes / no	Emphysema	yes / no	Myocardial infarction	yes / no
Arthritis	yes / no	GERD	yes / no	Nerve / muscle disease	yes / no
Cancer	yes / no	Clotting disorder	yes / no	Osteoporosis	yes / no
CHF	yes / no	Hyperlipidemia	yes / no	Anxiety	yes / no
Heart Murmur	yes / no	Hypertension	yes / no	Depression	yes / no
COPD	yes / no	Kidney disease	yes / no	Substance abuse	yes / no
Thyroid disease	yes / no	Other illnesses	_____		

Surgical History :

Appendectomy	yes / no	Cosmetic surgery	yes / no	Prostate surgery	yes / no
Brain surgery	yes / no	Eye surgery	yes / no	Colon/intestine surgery	yes / no
Breast surgery	yes / no	Fracture surgery	yes / no	Spine surgery	yes / no
CABG	yes / no	Hernia repair	yes / no	Cholecystectomy	yes / no
Valve replacement	yes / no	Knee replacement	yes / no	Vasectomy	yes / no
Colon surgery	yes / no	Hip replacement	yes / no	Thoracotomy	yes / no

Other _____

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Family History:

	Deceased	Alcohol or Drug Abuse	Cancer	Blood Clotting Disorder	COPD	Depression	Diabetes	Heart Disease	Hyperlipidemia
Mother									
Father									
Sister									
Brother									
Daughter									
Son									
Maternal GM									
Maternal GF									
Paternal GM									
Paternal GF									

	Hypertension	Kidney Disease	Mental Illness	Stroke	Heart Attack	Coronary Artery Disease	Rhematologic Disease	Other
Mother								
Father								
Sister								
Brother								
Daughter								
Son								
Maternal GM								
Maternal GF								
Paternal GM								
Paternal GF								

☐ Adopted ☐ Family History Unknown

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Social History:

Tobacco Use: ☐ cigarettes ☐ cigars ☐ pipe ☐ smokeless (e-cigarettes)

Quit date _____

Packs/day _____

Years smoked _____

Alcohol Use: ☐ beer ___ per week

☐ wine ___ glasses per week

☐ liquor ___ shots per week

Drug Use: ☐ Marijuana

☐ Other _____

Chemical Dependency Treatment ☐

How long sober _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: _____

Please describe your work activities:

_____

_____

Please describe your living arrangements:

□ Live alone □ Live with _____
□ Apartment / townhome
□ House
□ Shelter
□ Group Home
□ Nursing Home / Assisted Living

To whom do you turn for help in a crisis ? _____

Do you need help with your daily routine ? _____

Please mark the following regarding your level of activity and ability to get around: □ no problems

□ fall easily □ can't use stairs □ confined to bed □ painful to walk □ unable to walk

Assistance device: □ cane □ wheelchair □ scooter □ other _____

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Review of Systems (Please check box for current symptoms):

General-
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin-
□ Rashes
□ Dryness
□ Lumps
□ Itching
□ Sores / Wounds
□ Color changes
□ Hair and nail changes

Head-
□ Headache
□ Head injury
□ Neck Pain

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-
□ Vision loss / changes
□ Glasses or contacts
□ Pain in eyes
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks in vision
□ Glaucoma
□ Cataracts

Nose-
□ Stuffiness
□ Discharge
□ Hay fever
□ Nosebleeds
□ Sinus pain

Throat-
□ Bleeding
□ Thrush
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Dentures
□ Dental pain

Respiratory-

Cardiovascular-
□ Chest pain
□ Chest tightness
□ Palpitations
□ Difficulty breathing when lying down
□ Snoring
□ Wheezing
□ Painful breathing
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath

Breasts-
□ Lumps
□ Pain
□ Discharge
□ Self-exams
□ Breast-feeding

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Vomiting
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□ Yellow eyes or skin
□ Abdominal pain

Urinary-
□ Frequency
□ Urgency
□ Burning or pain urinating
□ Blood in urine
□ Incontinence
□ Change in urinary flow / strength

GYN-
□ Pelvic pain
□ Pregnant
□ Planning to get Pregnant
□ Menopause
□ Endometriosis

Vascular-
□ Calf pain with walking
□ Leg cramping
□ Swelling

Musculoskeletal-
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor
□ Memory difficulty

Hematologic-

Immunologic-
□ Easy bruising
□ Easy bleeding
□ Allergies

Endocrine-
□ Head or cold intolerance
□ Change in sweating
□ Frequent urination
□ Thirst
□ Change in appetite

Psychiatric-
□ Nervousness / anxiety
□ Stress
□ Depression
□ Hallucination
□ Post traumatic stress

Withdrawal symptoms-
□ Nausea
□ Trouble sleeping
□ Irritable
□ "Crawly" skin
□ Sweating
□ Muscle twitching

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What are your specific goals at our pain center ?

_____

What would you like to be able to do that is currently limited by your chronic pain?

_____

The information provided is true and accurate to the best of my knowledge. I understand that this information is being used for my care and treatment at the HealthEast Pain Center.

Patient Signature: _____

Date:_____

Guardian or representative (if needed) _____

Please complete and return this form in the enclosed envelope:

HealthEast Pain Center
1600 St. John's Blvd
Suite 101
Maplewood, MN 55109

We will call you to schedule an appointment once this form is completed and returned to us.