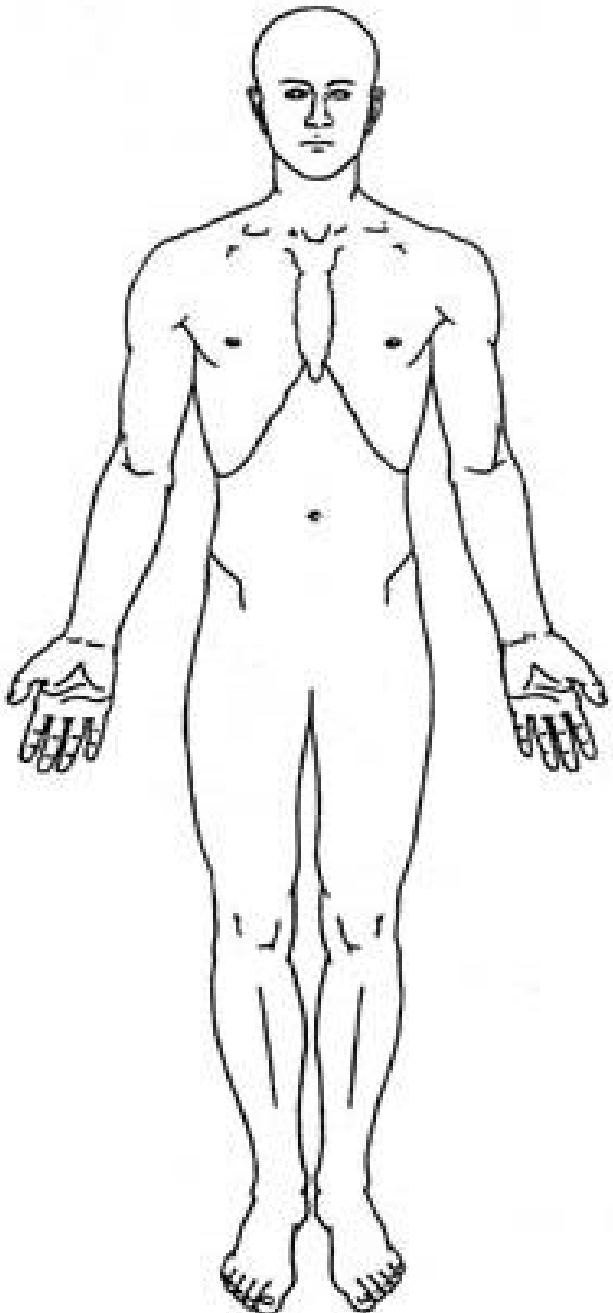
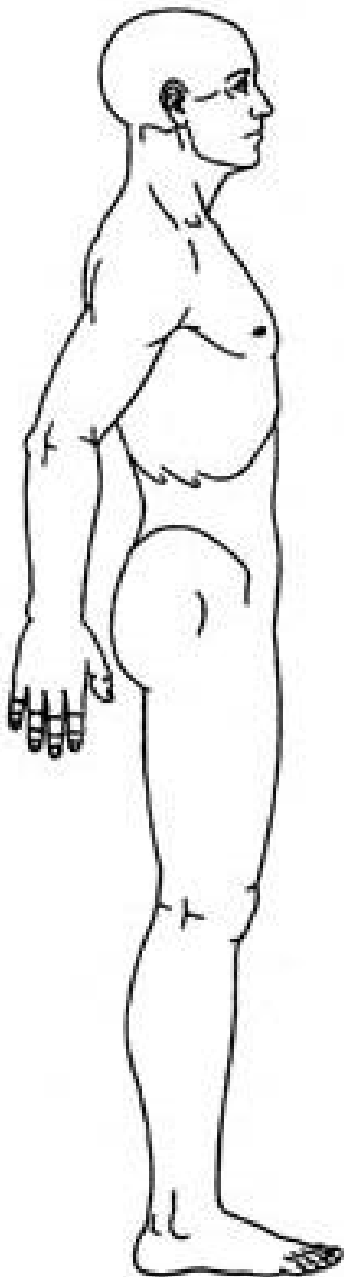
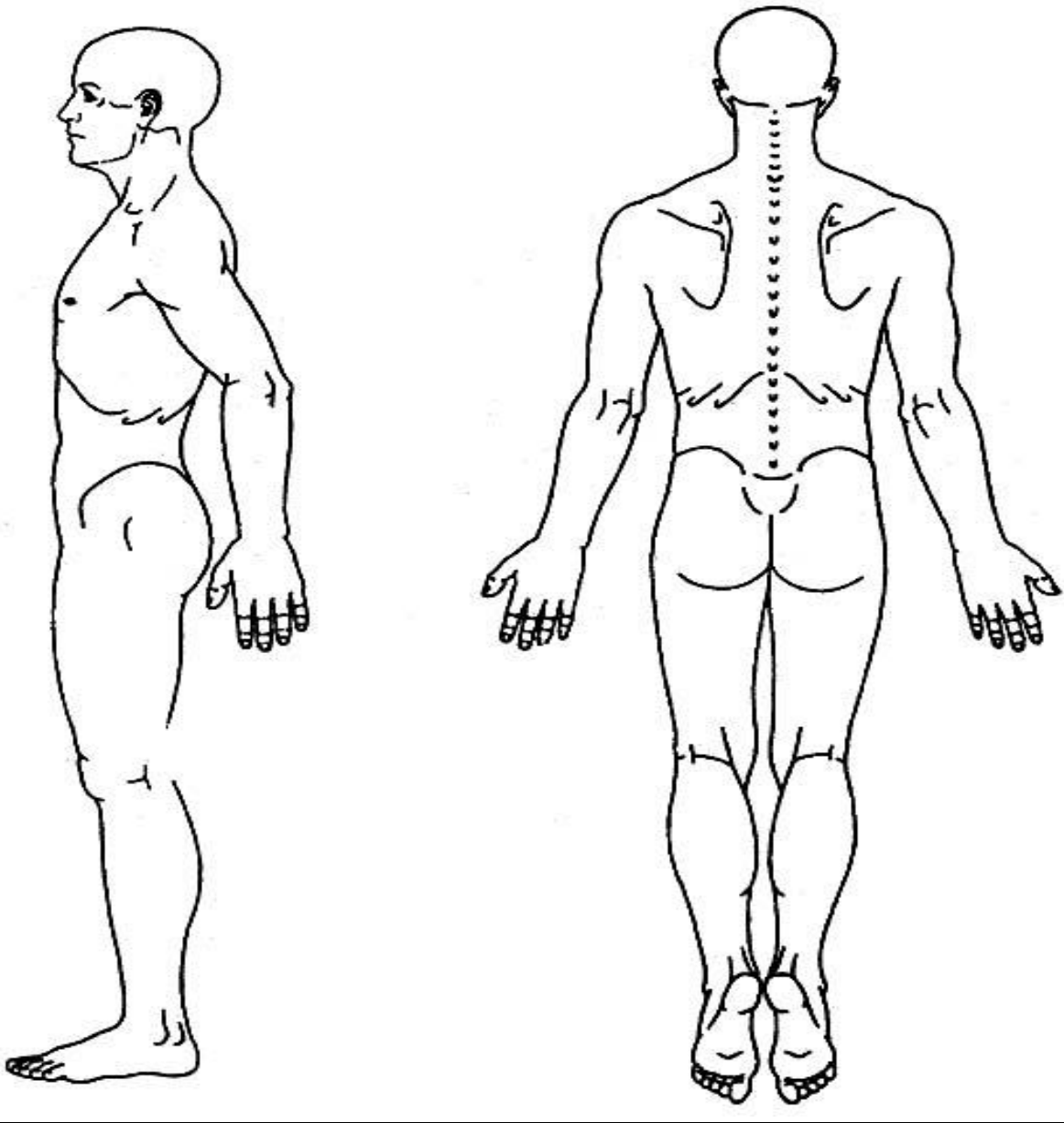




### ***PAIN***

**Location/Quality** Please mark, using the indicated symbol, the area(s) of your body where you experience the following: [dull, aching - oooo] [burning - vvvv] [sharp, stabbing - ///] [tingling, pins & needles - zzzz] [stiff, tight - +++++] [numb - xxx] [spasm - ssss] [throbbing - #####] [pressure - \*\*\*\*\*] [heat - hhhh] [cold - cccc]. Please use arrows to indicate symptoms that radiate. ***Please circle AND assign a number to each region of symptoms. Please use these numbers when answering subsequent questions to indicate the region to which you are referring .***





**Intensity** For each region, please place an "0" through the line to indicate the usual intensity of pain and an "x" to indicate the intensity of a flare.

Region #1	None	_____	Worst Possible
Region #2	None	_____	Worst Possible
Region #3	None	_____	Worst Possible
Region #4	None	_____	Worst Possible
Region #5	None	_____	Worst Possible
Region #6	None	_____	Worst Possible
Region #7	None	_____	Worst Possible

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**CHRONOLOGY/CAUSATION**

When did the present episode of pain begin? What caused it? Sudden or gradual onset? Has it improved, progressively worsened, or remain unchanged?

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If you have an attorney helping you with a personal injury or workman's compensation claim, please indicate their name & phone #.

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Is the current pain constant or intermittent? If the pain is intermittent, for how long does it last and how frequently does it occur?

---

Is there a time of day/week/month/year when it is typically better/worse?

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If this episode is not the first time in your life that you have experienced this or similar pain, when was? Sudden or gradual onset? Describe in detail what caused the pain the first time and whether the pain resolved, partially improved, or persisted.

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**IMPACT**

As a result of pain have you been unable to work or had to change jobs? Is your job still available to you? Explain.

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As a result of pain have you been unable to engage or been limited in self-care, household chores, sexual relations, social/leisure/athletic activities? Describe.

---

---

Do you have trouble with falling? Describe.

---

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PROVOCATION VS. RELIEF**

*Use numbers that reference regions of pain!*

The following make the pain:

	Better	Worse	If worse, how long is tolerable
<b>Postures</b>			
Lying on back	_____	_____	_____
Lying face down	_____	_____	_____
Lying on right side	_____	_____	_____
Lying on left side	_____	_____	_____
Sitting in a straight chair	_____	_____	_____
Sitting in an easy chair	_____	_____	_____
Standing still	_____	_____	_____
<b>Activities</b>			
Bending neck forward	_____	_____	_____
Bending neck backward	_____	_____	_____
Bending neck to the right	_____	_____	_____
Bending neck to the left	_____	_____	_____
Twisting neck to the right	_____	_____	_____
Twisting neck to the left	_____	_____	_____
Bending back forward	_____	_____	_____
Bending back backward	_____	_____	_____
Bending back to the right	_____	_____	_____
Bending back to the left	_____	_____	_____
Twisting back to the right	_____	_____	_____
Twisting back to the left	_____	_____	_____
Standing up from sitting	_____	_____	_____
Breathing	_____	_____	_____
Laughing	_____	_____	_____
Lifting	_____	_____	_____
Chewing	_____	_____	_____

	Better	Worse	If worse, how long is tolerable
Swallowing	_____	_____	_____
Sexual Intercourse	_____	_____	_____
Driving	_____	_____	_____
Walking	_____	_____	_____
Climbing stairs	_____	_____	_____
Descending stairs	_____	_____	_____
<b>Reflexes</b>	_____	_____	_____
Bowel movement	_____	_____	_____
Urination	_____	_____	_____
Coughing	_____	_____	_____
Sneezing	_____	_____	_____
Gagging	_____	_____	_____
Vomiting	_____	_____	_____
Orgasm	_____	_____	_____
<b>Treatments</b>	_____	_____	_____
Traction	_____	_____	_____
Heat	_____	_____	_____
Cold	_____	_____	_____
Stretching	_____	_____	_____
Massage	_____	_____	_____
Injections	_____	_____	_____
Heel lifts/orthotics	_____	_____	_____
Bite applications	_____	_____	_____
<b>Other</b>	_____	_____	_____
Fatigue	_____	_____	_____
Emotional stress	_____	_____	_____
Menstruation	_____	_____	_____

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Describe how exercise has altered your symptoms? \_\_\_\_\_

\_\_\_\_\_

Have you ever experienced joint manipulation or "adjustments" - from whom? when, why, results? \_\_\_\_\_

\_\_\_\_\_

**CONCURRENT or RECENT SYMPTOMS** Explain; noting the cause.

Sleep: do you have trouble falling asleep? Staying sleep? \_\_\_\_\_

\_\_\_\_\_

Mood/Energy \_\_\_\_\_

Thinking/Memory/Dizziness/Faintness \_\_\_\_\_

\_\_\_\_\_

Eyes/Visual \_\_\_\_\_

\_\_\_\_\_

Ears/Hearing \_\_\_\_\_

Lungs/Respiration \_\_\_\_\_

Nasal/Sinus/Smell \_\_\_\_\_

Mouth/Dental/Taste/Throat/Swallowing/Speech \_\_\_\_\_

\_\_\_\_\_

Abdomen/Digestion/Rectum/Elimination \_\_\_\_\_

\_\_\_\_\_

Heart/Circulation \_\_\_\_\_

\_\_\_\_\_

Genitalia/Urination/Sexual function/Breasts/Menstruation \_\_\_\_\_

\_\_\_\_\_

Extreme hunger/thirst or intolerance of heat/cold \_\_\_\_\_

\_\_\_\_\_

Weight gain/loss - explain \_\_\_\_\_

Skin/Hair/Other \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**INVESTIGATIONS**

List the physicians/dentists/therapists with whom you have consulted regarding your pain. \_\_\_\_\_

\_\_\_\_\_

Have you been told that you must learn to live with your pain? By whom?

\_\_\_\_\_

If any of the following have been performed to investigate your pain, indicate what region and results:

X-rays \_\_\_\_\_

CT scan \_\_\_\_\_

MRI scan \_\_\_\_\_

Bone scan \_\_\_\_\_

Arthrogram \_\_\_\_\_

Myelogram \_\_\_\_\_

Discogram \_\_\_\_\_

EMG (electromyogram) \_\_\_\_\_

EEG (electroencephalogram) \_\_\_\_\_

Neuropsych evaluation \_\_\_\_\_

***FAMILY HISTORY***

Do any diseases tend to "run in your family? \_\_\_\_\_

Do other members of your family have significant problems with pain?

\_\_\_\_\_

Is there or has there been any incidence of physical, sexual, and/or substance (drugs, alcohol, nicotine, caffeine, food) abuse in your family?

\_\_\_\_\_

\_\_\_\_\_

***ALLERGIES and INTOLERANCES to MEDICATIONS***

\_\_\_\_\_

\_\_\_\_\_



Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

***SURGICAL & ILLNESS HISTORY When? Why?***

Eyes/Ears \_\_\_\_\_

Nose/Sinus/Mouth/Throat \_\_\_\_\_

Dental: Wisdoms extracted - When? Why? \_\_\_\_\_

Braces - When? \_\_\_\_\_ Dentures? \_\_\_\_\_

Bridges? \_\_\_\_\_ Other? \_\_\_\_\_

Lungs/Heart/Circulation \_\_\_\_\_

Abdomen/Rectum \_\_\_\_\_

Pelvis/Genitalia \_\_\_\_\_

# of Pregnancies \_\_\_\_\_ Births \_\_\_\_\_ C-sections \_\_\_\_\_

Episiotomies \_\_\_\_\_ Miscarrages \_\_\_\_\_ Abortions \_\_\_\_\_

Neurological \_\_\_\_\_

Psychological \_\_\_\_\_

Musculoskeletal (other than trauma related) \_\_\_\_\_

Skin/Hair \_\_\_\_\_

Glandular/Other \_\_\_\_\_

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

The drawings on pages 3 & 4 are reproductions from: Myofascial Pain and Dysfunction - The Trigger Point Manual by Janet Travell, MD and David Simons, MD. Volume One. pp. 47 -49. Williams and Wilkins. Baltimore/London. 1983.