PALM BEACH PAIN, LLC

Patient Name: _____ Date: _____

DOB: _____ SSN: _____ - _____ - _____

1. My pain is located in the _____
2. For how long: Years _____ Months _____
3. What is the average pain intensity (circle one): 0 (none) 1 2 3 4 5 6 7 8 9 10 (worst)
4. How the pain started (circle one): Sudden Progressive
5. Does the pain radiate? (circle one) No Yes, where _____
6. Characteristics of the pain (circle one):
   Burning Aching Dull Numbing Throbbing
   Sharp Shooting Tingling Other _____
7. What does make your pain better: _____
8. What does make your pain worst: _____
9. Previous treatments for pain (circle one)
   Physical Therapy Massage Therapy Acupuncture Herbal medicine
   Injections (specify) _____ Result: Good Didn't help
   Medications for pain (specify) _____
10. Past medical history (circle one)
    Diabetes Hypertension High Cholesterol Seizures Parkinson's
    CAD/MI (heart) CHF (heart failure) A fib Asthma COPD
    Restless legs Pulmonary emboly TIA/Stroke DVT Migraine
    Depression Anxiety Fibromyalgia MS Neuropathy
    Cancer (type) _____ Other _____
11. Medications (specify): _____
12. Allergies (specify): _____
13. Surgeries (List) _____
14. Social History: Marital status (circle one): Single Married Widow Separated
    Place of birth _____ Living in Palm Beach area since _____
    Occupation _____ If retired or disabled, former occupation _____
    Tobacco use (circle one): Never Former (year you quit) _____ Current (cigarettes/day) _____
    Alcohol use (circle one): Never Social Daily Former abuser (year you quit) _____
    Marijuana use (circle one): Recreational Medical (with card)
    Recreational drugs: Never Yes, type _____ Former abuser (year you quit) _____
15. Family History
    Father: Alive (specify medical problems) _____ Deceased (reason) _____
    Mother: Alive (specify medical problems) _____ Deceased (reason) _____