History of Present Illness Worksheet

Patient Name: ____ Date of Birth: _____________________

1. Please describe the location of the pain you are here for today. *Example : Neck, lower back*

2. Does your pain radiate into your arm/arms or leg/legs: ❑ Yes ❑ No **If YES, please describe.**
   Example: pain radiates into my right arm

3. Are you Left or Right Handed? ❑ Left ❑ Right

4. When did this pain start? *Example: June of 2017*

5. Is this a work-related injury? ❑ Yes ❑ No

6. Are you currently working? ❑ Yes ❑ No

7. In your opinion, can you specify any events that could have caused your pain? *Example: a fall or an accident.*
   Please describe the event briefly:

8. Does this pain interfere with any of these activities:
   ❑ Usual daily activities *i.e. walking, sitting.* ❑ Work activities ❑ Sleep

9. Do you experience any of the following: ❑ **Numbness** ❑ **Tingling** ❑ **Weakness**

10. Location where you experience the above symptom(s):

11. When is your pain worse: ❑ Mornings ❑ Afternoons ❑ Evenings ❑ Night

12. What makes your pain worse? ❑ Sitting ❑ Standing ❑ Bending ❑ Other: _____________________

13. What makes your pain better? ❑ Sitting ❑ Standing ❑ Bending ❑ Other: _____________________

14. Pain Character, how would you describe your pain? *Please check one or more:*
    ❑ Burning ❑ Sharp ❑ Aching ❑ Deep ❑ Annoying ❑ Gnawing ❑ Stabbing

15. On the scale of 0 to 10, **0 being no pain and 10 being the worst pain you can imagine**, please describe your pain:

    At its Worst: **0 1 2 3 4 5 6 7 8 9 10**

    On Average: **0 1 2 3 4 5 6 7 8 9 10**

    At its Least: **0 1 2 3 4 5 6 7 8 9 10**

    Today: **0 1 2 3 4 5 6 7 8 9 10**

16. Have you taken any over the counter medications to treat your pain? *Examples: Acetaminophen, Aleve, Advil*
    ❑ Yes ❑ No **If YES, Please complete the following:**
    Name of the Medication: ____
    Date taken (month/year): ___________/_____________ Taking currently: ❑ Yes ❑ No
    Degree of relief: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

Name of the Medication: ____
Date taken (month/year): ________/__________ Taking currently: ❑ Yes ❑ No
Degree of relief: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

Name of the Medication: ____
Date taken (month/year): ________/__________ Taking currently: ❑ Yes ❑ No
Degree of relief: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

17. Have you taken any prescription medications for pain? ❑ Yes ❑ No **If YES, please complete the following:**
    Name of the Medication: ____
    Date taken (month/year): ________/__________ Taking currently: ❑ Yes ❑ No
    Degree of relief: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

    Name of the Medication: ____
    Date taken (month/year): ________/__________ Taking currently: ❑ Yes ❑ No
    Degree of relief: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

    Name of the Medication: ____
    Date taken (month/year): ________/__________ Taking currently: ❑ Yes ❑ No
    Degree of relief: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

18. Have you had any physical therapy for this pain? ❑ Yes ❑ No **If YES,** What dates did you attend physical therapy (month/year to month year): _______/_________ through _______/_________

19. Are you currently in physical therapy: ❑ Yes ❑ No **If YES, please answer the following:**
    How many weeks did you attend: ______________
    How effective was physical therapy in relieving your pain? Please circle one:
    10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

20. Have you had any Chiropractic treatments for this pain? ❑ Yes ❑ No **If YES, please answer the following:**
    When did you receive Chiropractic treatment? (month/year) _________/_________
    How many weeks did you attend chiropractic treatments? __________
    How effective was it? Please circle one: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

21. Are you currently having chiropractic treatments? ❑ Yes ❑ No

22. Have you tried any home exercises for this pain? ❑ Yes ❑ No **If YES, please answer the following:**
    When did you try home exercises? (month/year): ______/________
    How many weeks: _______
    How effective was it? Please circle one: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

23. Are you currently in a home exercise program? ❑ Yes ❑ No

24. Have you tried Acupuncture for this pain? ❑ Yes ❑ No **If YES, please answer the following:**
    When did you try acupuncture? (month/year): _______/__________
    How many weeks: _________
    How effective was it? Please circle one: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

25. Currently in acupuncture treatment? ❑ Yes ❑ No

26. Have you tried a TENS unit for this pain? ❑ Yes ❑ No **If YES, please answer the following:**
    When did you try a TENS unit? (month/year): _______/__________
    How many weeks: _________
    How effective was it? Please circle one: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

27. Have you tried heat for this pain? ? ❑ Yes ❑ No **If YES, please answer the following:**
    When did you try heat? (month/year): _______/__________
    How many weeks: _________
    How effective was it? Please circle one: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

28. Have you tried ice for this pain? ❑ Yes ❑ No **If YES, please answer the following:**
    When did you try ice? (month/year): _______/__________
    How many weeks: _________
    How effective was it? Please circle one: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

29. Have you tried spinal injections for this pain? ❑ Yes ❑ No **If YES, please answer the following:**
    When did you try a spinal injection(s)? (month/year): _______/__________
    How many injections: _________
    How effective was it? Please circle one: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**
    Who was the performing physician (if known): ____
    Type of injection (if known): ____

30. Have you ever had spine surgery for this pain? ❑ Yes ❑ No **If YES, please answer the following:**
    When did you have spinal surgery(s)? (month/year): _______/__________
    How effective was it? Please circle one: **10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**
    Who was the performing physician (if known): ____
    Type of surgery (if known): ____

31. Have you had any of the following tests in relation to this pain:
    MRI scan
    Region of body, *Example: lower back*: ______________________________
    Date, (month/year): __________/____________
    Facility where MRI scan was performed: ____

CT scan

Region of body, *Example: lower back*: ______________________________

Date, (month/year): __________/___________

Facility where CT scan was performed: ____

X-ray

Region of body, *Example: lower back*: ______________________________

Date, (month/year): __________/___________

Facility where X-ray was performed: ____

32. What are your expectations from today's visit?

❑ Learning about my treatment options ❑ Receiving an injection ❑ Other non-injection treatments

❑ Other, please explain: ____