momenta PAIN CARE

PATIENT MEDICAL HISTORY

PATIENT NAME:______________________________ TODAY'S DATE: ______________

FAMILY PHYSICIAN: ____________________ REFERRING PHYSICIAN: ____________________

PATIENT DATE OF BIRTH:______________ AGE: ________ HEIGHT: ________ WEIGHT: ________

DATE THAT YOUR SYMPTOMS BEGAN OR DATE OF YOUR INJURY: ______________________________

HAVE YOU HAD ANY PREVIOUS PROBLEMS? ☐ YES ☐ NO | IF YES, WHEN? ______________________

IS THE CURRENT PROBLEM A RESULT OF: ☐ WORK RELATED ACCIDENT ☐ MOTOR VEHICLE ACCIDENT

IF THIS IS A WORK-RELATED INJURY, IS YOUR VISIT TODAY RELATED TO A WORKERS COMPENSATION CLAIM? ☐ YES ☐ NO

HOW DID THE INJURY OCCUR OR SYMPTOMS BEGIN? (PLEASE GIVE A BRIEF EXPLANATION):

____

____

____

IF CURRENTLY WORKING, IS THE PAIN AFFECTING YOUR WORK? IF YES, HOW? ______________________

PLEASE LIST ANY OTHER ACTIVITIES LIMITED BY YOUR PAIN: ______________________

HOW WOULD YOU DESCRIBE YOUR PAIN?

☐ CONTINUOUS
☐ INTERMITTENT
☐ DULL
☐ ACHING
☐ HEAVY
☐ THROBBING
☐ SHARP
☐ SHOOTING
☐ STABBING
☐ TENDER
☐ GNAWING
☐ PRESSURE
☐ BURNING/HOT
☐ CRAMPING
☐ TINGLING | EXHAUSTING
☐ SICKENING
☐ FEARFUL
☐ PUNISHING | CRUEL

PLEASE LIST ANY OTHER AREAS OF PAIN: ______________________

____

____

RATE YOUR PAIN: 0 = NO PAIN | 10 = WORST PAIN IMAGINABLE

CURRENTLY: ______________________

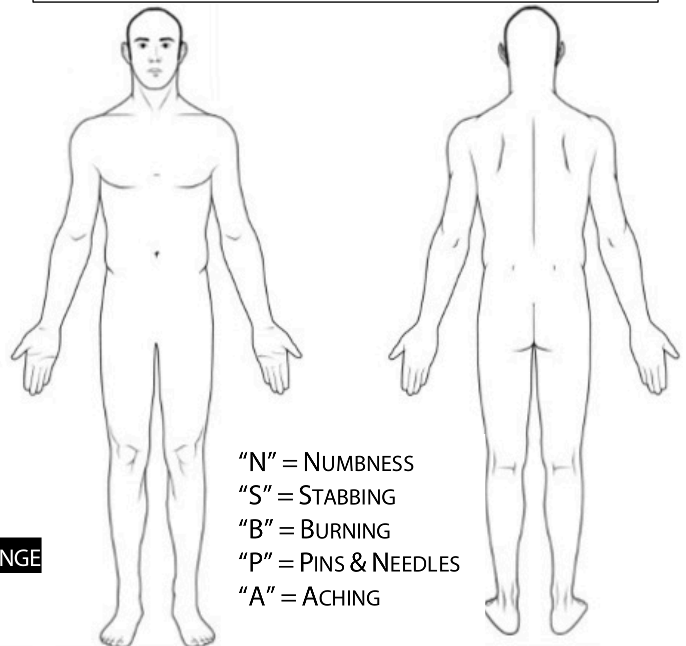
AT YOUR BEST: ______________________

AT YOUR WORST: ______________________

HOW DO THE FOLLOWING ACTIVITIES AFFECT YOUR PAIN?

	INCREASES PAIN	DECREASES PAIN	NO CHANGE
RESTING	☐	☐	☐
LYING DOWN	☐	☐	☐
SITTING	☐	☐	☐
STANDING	☐	☐	☐
BENDING	☐	☐	☐
WALKING	☐	☐	☐
CHANGING POSITIONS	☐	☐	☐
WORKING	☐	☐	☐
COUGHING/SNEEZING/STRAINING	☐	☐	☐
LIFTING	☐	☐	☐
PROLONGED POSITION	☐	☐	☐

PLEASE DRAW THE LOCATION OF YOUR PAIN USING THE KEY BELOW:



"N" = NUMBNESS
"S" = STABBING
"B" = BURNING
"P" = PINS & NEEDLES
"A" = ACHING

ARE YOU EXPERIENCING:

☐ NUMBNESS | TINGLING WHERE?______________
☐ WEAKNESS
☐ LOSS OF BOWEL/BLADDER CONTROL? EXPLAIN:______________
☐ SLEEP DISTURBANCE
☐ ANXIETY
☐ DEPRESSION

PAIN TREATMENT HISTORY

TREATMENT

☐ I HAVE HAD NO TREATMENT FOR MY SYMPTOMS TO DATE

PLEASE SELECT ALL OF THE FOLLOWING TREATMENTS THAT YOU HAVE USED FOR PAIN RELIEF:

	HELPED PAIN	WORSENED PAIN	NO CHANGE	DATES OF VISIT
ACUPUNCTURE				
BIOFEEDBACK				
BRACE SUPPORT				
CHIROPRACTIC				
ELECTRICAL STIMULATION				
HOT/COLD PACKS				
INJECTION THERAPY				
MASSAGE THERAPY				
MEDICATIONS				
PHYSICAL THERAPY				
TENS UNITS				
TRACTION				

PAIN MEDICATIONS

☐ I HAVE NOT TRIED ANY MEDICATIONS INCLUDING OVER THE COUNTER MEDICATIONS

PLEASE LIST ALL PAIN MEDICATIONS THAT YOU HAVE BEEN ON AT ANY POINT FOR YOUR CURRENT PAIN, INCLUDING OVER THE COUNTER MEDICATIONS:

MEDICATION NAME	DOSE	FREQUENCY	HELPED	NO HELP

PAIN CLINIC

☐ I HAVE NOT BEEN TREATED BY ANOTHER PAIN PHYSICIAN OR CLINIC

PLEASE LIST THE NAMES OF OTHER PAIN PHYSICIANS YOU HAVE SEEN, ALONG WITH A BRIEF DESCRIPTION OF THERAPY RECEIVED:

FACILITY | PHYSICIAN	DESCRIPTION OF THERAPY	DATES

PSYCHOLOGICAL | BEHAVIORAL THERAPY

☐ I HAVE NOT BEEN TREATED FOR PSYCHOLOGICAL HEALTH

PLEASE LIST THE NAMES OF PHYSICIANS YOU HAVE SEEN, ALONG WITH A BRIEF DESCRIPTION OF THERAPY RECEIVED:

FACILITY | PHYSICIAN	DESCRIPTION OF THERAPY	DATES

STEROID INJECTIONS

☐ I HAVE NOT HAD ANY INJECTIONS

IF YOU HAVE HAD ANY INJECTIONS, PLEASE PROVIDE THE INFORMATION BELOW:

DATE	LOCATION (LOW BACK, NECK?)	PERFORMED BY MD OR CRNA?	X-RAY GUIDED? Y OR N	RELIEF? NO OR MILD	RELIEF? TEMPORARY OR LONG LASTING ?	MADE SYMPTOMS WORSE? Y OR N

RESULTS OF INJECTION

SPINE SURGERY

☐ I HAVE NOT HAD SPINE SURGERY

IF YOU HAVE HAD SPINE SURGERY IN THE PAST, PLEASE PROVIDE THE INFORMATION BELOW:

DATE	LOCATION (LOW BACK, NECK?)	NAME OF SURGEON	RELIEF? NO OR MILD	RELIEF? TEMPORARY OR LONG LASTING ?	MADE SYMPTOMS WORSE? Y OR N

RESULTS OF INJECTION

DIAGNOSTICS TESTS AND IMAGING

☐ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS

PLEASE PROVIDE INFORMATION FOR ALL OF THE FOLLOWING TESTS YOU HAVE HAD THAT ARE RELATED TO YOUR CURRENT PAIN COMPLAINTS:

TEST	OF THE (NECK, BACK)	DATE	FACILITY
MRI			
X-RAY			
CT			
EMG			
MYELOGRAM			
OTHER:			

CURRENT MEDICATIONS | VITAMINS & SUPPLEMENTS:

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING, INCLUDING VITAMINS AND SUPPLEMENTS:

MEDICATION NAME	DOSE	FREQUENCY

Surgical History

☐ I Have Never Had Any Surgical Procedures Performed

Please List Any Surgical Procedures You Have Done In The Past, Including The Date:

Surgical Procedure	Dates

Did You Experience An Adverse Reaction To The Anesthesia? ☐ Yes ☐ No

If Yes, Please Explain:

____

____

Past Medical History

Select The Conditions That You Have Been Treated For In The Past:

General Medical| Diagnosed Conditions

☐ Cancer – Type____________________

☐ Cancer – Type____________________

Cardiovascular/Hematologic

☐ Anemia
☐ Stroke/TIA
☐ Heart Valve Disorders
☐ Peripheral Vascular Disease
☐ Heart Murmur
☐ Heart Attack
☐ Coronary Artery Disease

Urological

☐ Chronic Kidney Disease
☐ Kidney Stones
☐ Urinary Incontinence
☐ Dialysis

Gastrointestinal

☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Stomach Ulcers
☐ Constipation

Neurologic

☐ Multiple Sclerosis
☐ Peripheral Neuropathy
☐ Seizures

Behavioral

☐ Depression
☐ Anxiety

Head/Ears/Eyes/Nose/Throat

☐ Headaches
☐ Migraines
☐ Head Injury
☐ Glaucoma

Endocrine

☐ Hyperthyroidism
☐ Hypothyroidism
☐ Diabetes – Type________________

Respiratory

☐ Asthma
☐ Bronchitis/Pneumonia
☐ Emphysema/COPD

Musculoskeletal/Rheumatologic

☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Chronic Joint Pains

Other Conditions

☐
☐
☐

ALLERGIES

DO YOU HAVE ANY DRUG/MEDICATION ALLERGIES? ☐ YES ☐ NO

IF SO, PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

MEDICATION NAME	ALLERGIC REACTION

TOPICAL ALLERGIES: ☐ LATEX ☐ IODINE ☐ TAPE ☐ IV CONTRAST

FAMILY HISTORY

☐ UNKNOWN

PLEASE SELECT ALL THE APPROPRIATE DIAGNOSES AS THEY PERTAIN TO YOUR FIRST-DEGREE RELATIVES:

DIAGNOSIS	MOTHER	FATHER	SIBLING(S)	CHILD
ARTHRITIS				
HEADACHES/ MIGRAINES				
BRACE SUPPORT				
LIVER PROBLEMS				
SEIZURES				
CANCER				
HIGH BLOOD PRESSURE				
OSTEOPOROSIS				
STROKE				
DIABETES				
KIDNEY PROBLEMS				
RHEUMATOID ARTHRITIS				
BACK PROBLEMS				
HEART PROBLEMS				

☐ OTHER MEDICAL PROBLEMS:____

____

SOCIAL HISTORY

OCCUPATION: ______________________ EMPLOYER: ______________________

ARE YOU CURRENTLY WORKING? ☐ YES ☐ NO ☐ RETIRED ☐ DISABLED ☐ UNEMPLOYED

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EDUCATION: ☐ ELEMENTARY SCHOOL ☐ HIGH SCHOOL DIPLOMA ☐ GED ☐ SOME COLLEGE ☐ COLLEGE DEGREE ☐ TRADE SCHOOL

DO YOU EXERCISE? ☐ YES ☐ NO IF YES, WHAT TYPE OF EXERCISE? ______________________

HOBBIES | INTERESTS: ______________________

ALCOHOL USE: ☐ YES ☐ NO AMOUNT: ______________

TOBACCO USE: ☐ YES ☐ NO AMOUNT: ______________ E-CIGARETTE USE: ______________

ILLICIT/RECREATIONAL DRUG USE:

☐ DENIES ANY ILLICIT/RECREATIONAL DRUG USE ☐ CURRENTLY USES ILLICIT/RECREATIONAL DRUGS

☐ FORMERLY USED ILLICIT/RECREATIONAL DRUGS (NOT CURRENTLY USING)

HAVE YOU EVER ABUSED NARCOTIC OR PRESCRIPTION MEDICATIONS? ☐ YES ☐ NO

Review Of Systems

Please Select Any Of The Following Symptoms That You Are Currently Experiencing:

Constitutional:	☐ Fever	☐ Chills	☐ Night Sweats	☐ Weight Loss
	☐ Weight Gain	☐ Decreased Energy	☐ Loss Of Appetite	
HEENT:	☐ Runny Nose	☐ Nose Bleeds	☐ Sinus Congestion	☐ Hearing Loss
	☐ Vision Changes			
Skin:	☐ Rash	☐ Non-Healing Skin Lesions		
Neurologic:	☐ Seizure Disorder	☐ Tremors	☐ Dizziness/Fainting	☐ Weakness In Extremity
	☐ Paralysis	☐ Loss Of Balance		
Cardiac:	☐ Chest Pain/Angina	☐ Heart Palpitations	☐ Rapid Heart Rate	☐ Swelling In Extremities
Respiratory:	☐ Wheezing	☐ Blood Stained Sputum	☐ Sleep apnea	☐ Cough
	☐ Upper Respiratory Infection			
Gastrointestinal:	☐ Abdominal Pain	☐ Vomiting	☐ Heartburn	☐ Constipation
	☐ Bloody Stools	☐ Diarrhea		
GU/Nephro:	☐ Dysuria	☐ Hematuria	☐ Chronic Renal Failure	
Endocrine:	☐ Diabetes	☐ Heat Intolerance	☐ Cold Intolerance	☐ Thyroid Problems
	☐ Excessive Thirst	☐ Excessive Urination		
Genitourinary:	☐ Urinary Incontinence	☐ Pain With Urination	☐ Prostate Problems	☐ Post-Hysterectomy
	☐ Post-Menopausal	☐ Urinary Tract Infection	☐ Blood In Urine	☐ Kidney Stones
Hematologic:	☐ Anemia	☐ Swollen Lymph nodes	☐ Abnormal Bruising/Bleeding	
Musculoskeletal:	☐ Joint Pain	☐ Back Pain	☐ Neck Pain	☐ Muscle Pain
	☐ Joint Restrictions			
Psychiatric:	☐ Depression	☐ Anxiety	☐ Drug Use	☐ Stress
	☐ Sleep Disturbance	☐ Mood Changes		
Immunologic:	☐ HIV/AIDS			