TEXAS PAIN INSTITUTE
Phone: (817) 348-8600 Fax: (817) 348-8602

Pain Management History

Today's Date: _____ **Height:** _____
Patient Name: _____ **Weight:** _____ lbs
Date of Birth: _____

Current Pain Problem

Complete this form before your first appointment at Texas Pain Institute. Your careful answers will help us understand your pain problem and design the best treatment program for you.

Where is the Pain? (e.g., back, neck, arm, leg, joint, etc.)

_____

When Did the Pain Start?

_____

Describe Your Pain.

- ☐ Burning
- ☐ Shooting
- ☐ Stabbing
- ☐ Aching
- ☐ Throbbing
- ☐ Cramping
- ☐ Tingling
- ☐ Sharp
- ☐ Dull
- ☐ Numbness
- ☐ Weakness
- ☐ Pins & Needles
- ☐ Intermittent
- ☐ Constant
- ☐ Localized
- ☐ Radiating

What Makes the Pain Worse?

- ☐ Standing
- ☐ Sitting
- ☐ Walking
- ☐ Lying Down
- ☐ Lifting
- ☐ Other _____

What Eases the Pain?

- ☐ Medication
- ☐ Heat
- ☐ Ice
- ☐ Resting
- ☐ Walking
- ☐ Lying Down
- ☐ Bending Forward
- ☐ Other _____

Your Pain Right Now

Least 0 1 2 3 4 5 6 7 8 9 10 Worst

The Average Intensity of Your Pain This Week

Least 0 1 2 3 4 5 6 7 8 9 10 Worst

Your Pain at its Worst

Least 0 1 2 3 4 5 6 7 8 9 10 Worst

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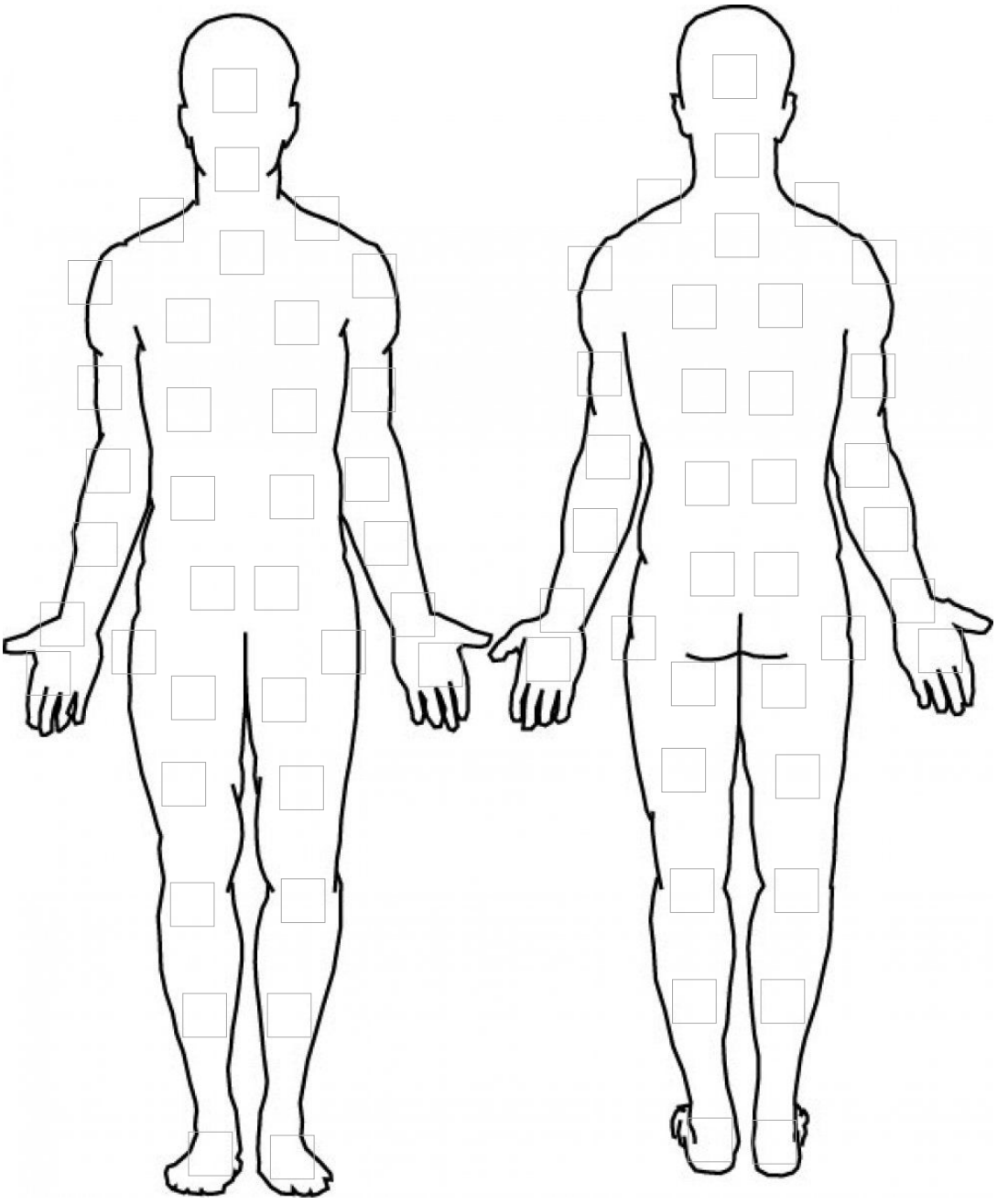
Pain Drawing

Mark the areas on your body where you feel pain.



FRONT **BACK**

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Treatment History

Any Previous Injections? (If so, please list type of injection)
☐ Yes ☐ No

What Was Your Response to Injections?

Do You Take Any Pain Medications? (If so, please list pain medications trialed)
☐ Yes ☐ No

Have You Had Any X-Rays / MRIs? (If so, when & where?)
☐ Yes ☐ No

Have You Seen a Surgeon? (If so, which surgeon did you visit with?)
☐ Yes ☐ No

Have You Had Any Physical Therapy? (If so, when & for how long?)
☐ Yes ☐ No

Patient Signature: _____ **Date:** _____ mm/dd/yyyy