

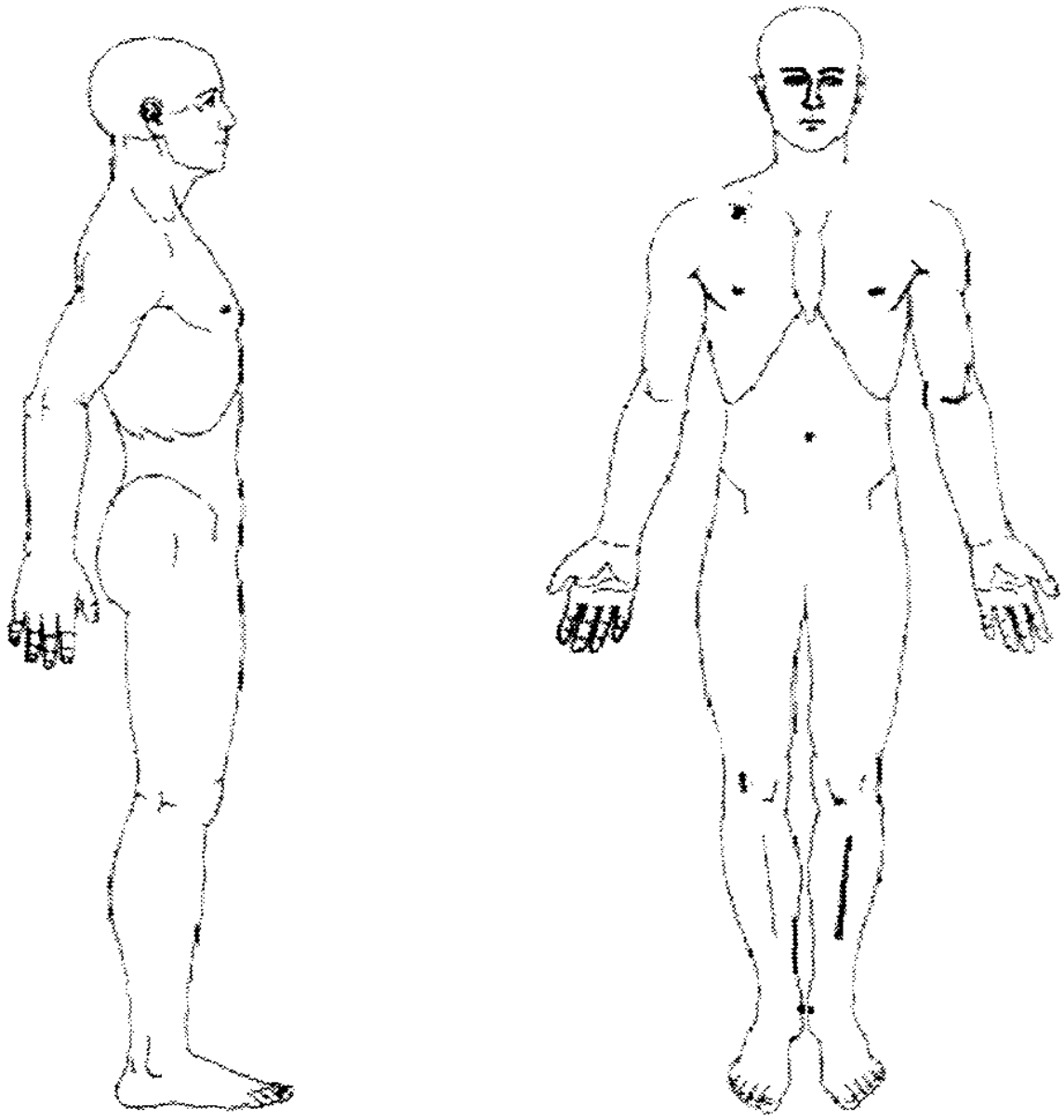
Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

### Chronic Pain and Headache History

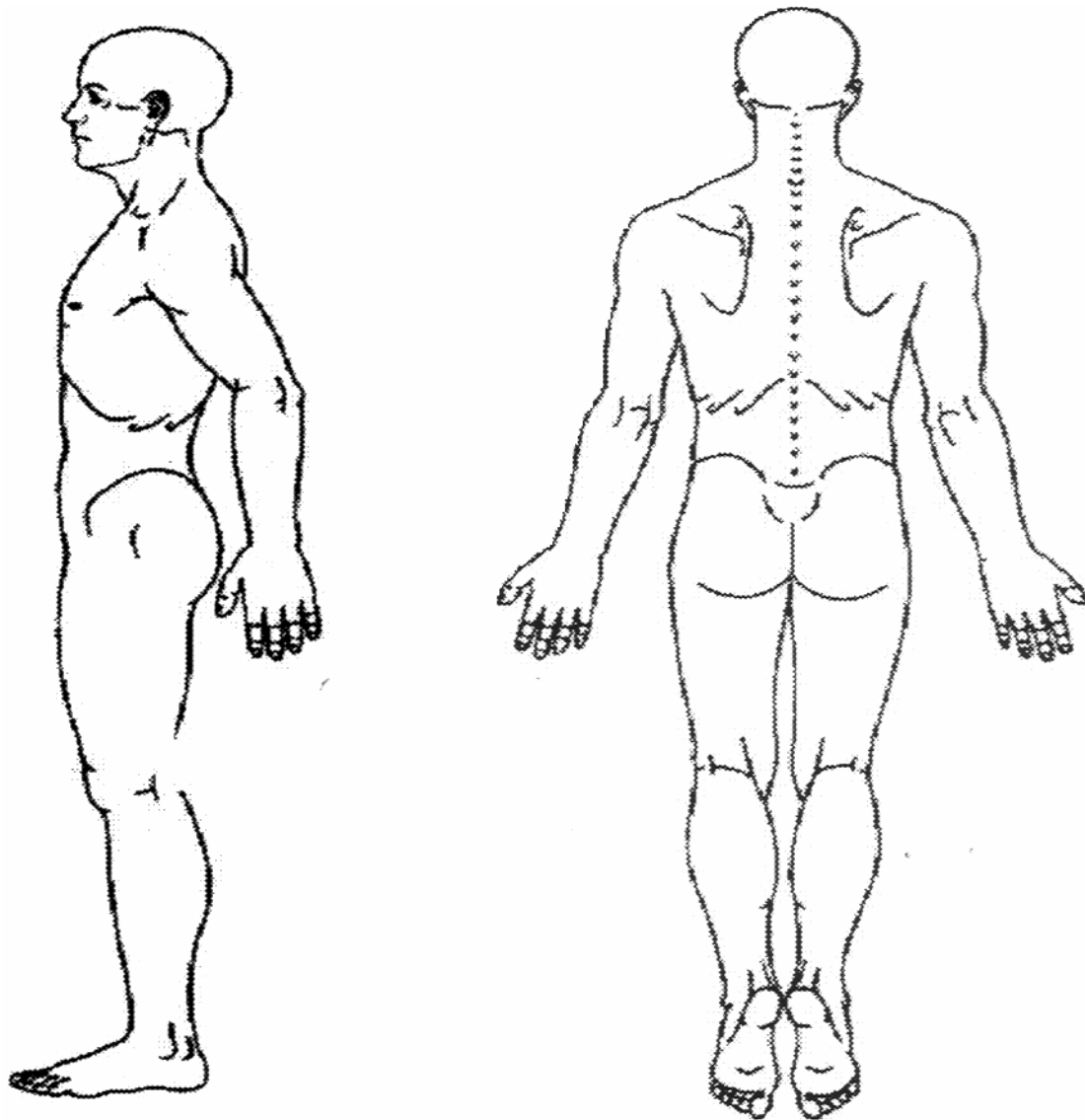
#### Location and Quality of Pain

Please mark the area(s) of your body where you experience pain with the appropriate symbol to indicate the type of pain: **oooo** - dull, aching; **bbbb** - burning; **////** - sharp, stabbing; **zzzz** - tingling, "pins and needles"; **++++** - stiff, tight; **nnnn** - numb; **ssss** - spasm; **tttt** - throbbing; **pppp** - pressure; **hhhh** - heat; **cccc** - cold. Use arrows to show how the pain radiates to other areas of the body, if applicable. Please circle each region and assign a number to it.



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**Intensity Scale**

For each numbered region in the pictures, place an “O” on the scale to show the *usual* intensity of the pain, and an “X” to show the intensity of a *flare-up*.

- 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

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### Cause and Timing of the Pain

When did the **present episode** of pain begin? \_\_\_\_\_

What caused it? \_\_\_\_\_

Sudden or gradual onset? \_\_\_\_\_

Has it improved, progressively worsened or remained unchanged? \_\_\_\_\_

Is the current pain constant or does it come and go? \_\_\_\_\_

If it comes and goes, how long does it last and how frequently does it occur? \_\_\_\_\_

Is there a time of the day, week, month or year when the pain is typically better or worse? \_\_\_\_\_

If you have **NOT** experienced this or similar pain, when was the first time that you felt it? \_\_\_\_\_

Sudden or gradual onset? \_\_\_\_\_

Describe in detail what caused the pain the first time: \_\_\_\_\_

Did the pain resolve, improve partially or persist? \_\_\_\_\_

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**Impact**

Have you been unable to work or had to change jobs because of the pain? Is your job still available to you?  
Please explain:

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Have you been unable to or needed help to do self-care, household chores, sexual relations, social, leisure or athletic activities? Please describe:

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Do you have trouble with falling? Please describe:

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List the symptoms in the follow categories that began when the pain started or that you think are caused by the pain:

Sleep \_\_\_\_\_

Mood or Energy \_\_\_\_\_

Thinking, memory, dizziness or faintness \_\_\_\_\_

Eyes or vision \_\_\_\_\_

Ears or hearing \_\_\_\_\_

Lungs or breathing \_\_\_\_\_

Nose, sinus or smell \_\_\_\_\_

Mouth, dental, taste, throat, swallowing, speech \_\_\_\_\_

Abdomen, digestion, rectum or elimination \_\_\_\_\_

Heart or circulation \_\_\_\_\_

Genitalia, urination, sexual function, breasts or menstruation \_\_\_\_\_

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

Weight gain or loss \_\_\_\_\_

Skin or hair \_\_\_\_\_

Other \_\_\_\_\_

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**What Makes it Better or Worse**

Enter the region number from pain diagrams in the "better" or "worse" column as appropriate. If worse, describe how long you can tolerate the pain.

	<u>Better</u>	<u>Worse</u>	<u>How long I can tolerate the pain...</u>
<b>Postures</b>			
Lying on back	_____	_____	_____
Lying face down	_____	_____	_____
Lying on right side	_____	_____	_____
Lying on left side	_____	_____	_____
Sitting in a straight backed 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 your back forward	_____	_____	_____
Bending your back backward	_____	_____	_____
Bending your back to the right	_____	_____	_____
Bending your back to the left	_____	_____	_____
Twisting your back to the right	_____	_____	_____
Twisting your back to the left	_____	_____	_____
Standing up from a seated position	_____	_____	_____
Breathing	_____	_____	_____
Laughing	_____	_____	_____
Lifting	_____	_____	_____
Chewing	_____	_____	_____
Swallowing	_____	_____	_____
Sexual Intercourse	_____	_____	_____
Driving	_____	_____	_____
Walking	_____	_____	_____
Climbing stairs	_____	_____	_____
Going down stairs	_____	_____	_____
<b>Reflexes</b>			
Bowel movement	_____	_____	_____
Urination	_____	_____	_____
Coughing	_____	_____	_____
Sneezing	_____	_____	_____
Gagging	_____	_____	_____
Vomiting	_____	_____	_____
Orgasm	_____	_____	_____

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Treatments	<u>Better</u>	<u>Worse</u>	<u>How long I can tolerate the pain...</u>
Traction	_____	_____	_____
Heat	_____	_____	_____
Cold	_____	_____	_____
Stretching	_____	_____	_____
Massage	_____	_____	_____
Injections	_____	_____	_____
Heel lifts or orthotics	_____	_____	_____
Bite blocks or applications	_____	_____	_____
<b>Other</b>			
Fatigue	_____	_____	_____
Menstruation	_____	_____	_____
Emotional Stress	_____	_____	_____

Describe how exercise has impacted your symptoms: \_\_\_\_\_

Have you ever experiences joint manipulation or "adjustments"? From whom? When? Why? Results? \_\_\_\_\_

### Investigations

List the physicians, dentists and therapist with whom you have seen about this pain? \_\_\_\_\_

Have you been told that you must learn to live with this pain? By whom? \_\_\_\_\_

If studies have been performed to investigate this pain, please list the area studied and the results:

X-rays	_____
CT Scan	_____
MRI	_____
Bone Scan	_____
Arthrogram	_____
Myelogram	_____
Discogram	_____
Electromyogram (EMG)	_____
Electroencephalogram (EEG)	_____
Neuropsychological Evaluation	_____

