

PAIN HISTORY

➤ **ONLY Patients of DR. DIMICK Should Fill Out This Form**

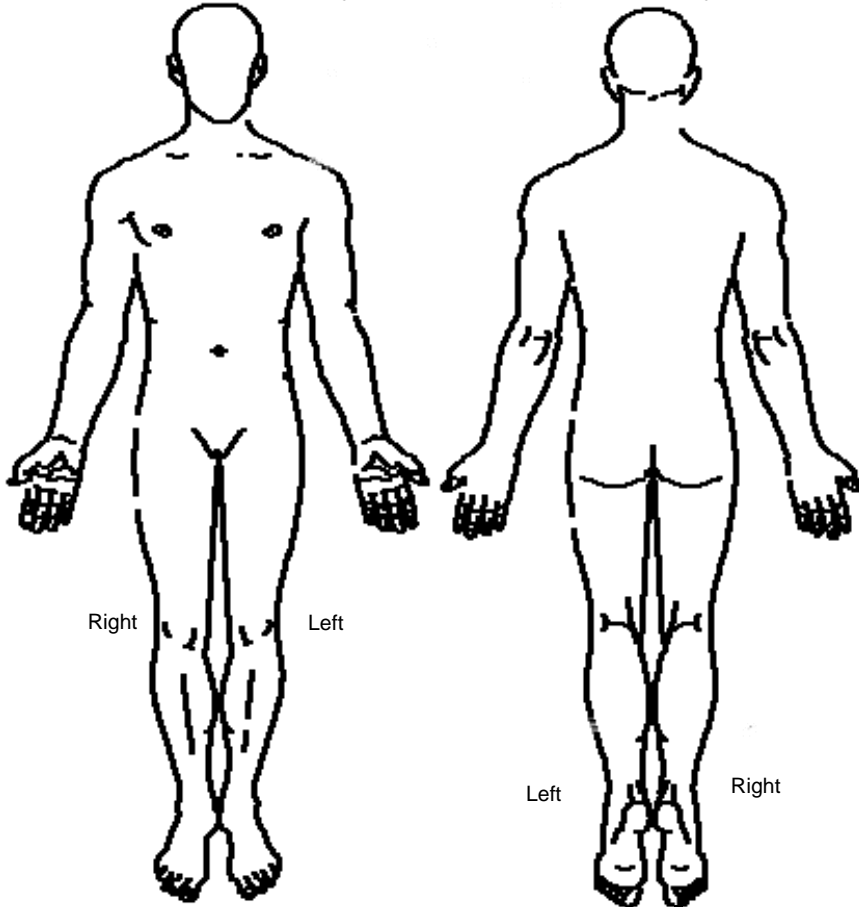
Patient's Name: _____ Date of Birth: _____ Today's Date: _____

Occupation / Job: _____

Do you like your job? _____ Do you plan to be at your job in 6 months? _____

TELL US ABOUT YOUR PAIN:

To start, please draw your face. Now mark the areas on your body where you feel the sensations. Use the symbols in the box below to mark the areas of your pain. Then mark the areas that your pain spreads to. Please be sure you include all affected areas. You may also use words and descriptions.



<i>On the drawings to the left, please shade in the area(s) of your pain, using the following symbols:</i>	
Aching =	▲ ▲ ▲ ▲
Numbness =	= = = =
Pins & Needles =	0 0 0 0
Burning =	X X X X
Stabbing =	/ / / /

Further Description(s):

How bad is your pain today? *(Please circle the number below that best indicates your current pain level.)*
 (No pain at all) 0 1 2 3 4 5 6 7 8 9 10 (Pain as bad as it can be)

Please answer the following questions about the history of your pain:

What medications have you tried for your pain? _____
 What were their effects? _____
 Have you been to Physical Therapy? _____ Where? _____ Was it helpful? _____
 Have you had chiropractic adjustments? _____ Where? _____ Was it helpful? _____
 Have you ever worn a brace for your back or neck? _____ What type? _____ Was it helpful? _____
 Have you experienced any change in or loss of bowel or bladder control? _____
 When you strain, cough, or sneeze do your legs hurt? _____ Have you had any fever or hard, shaking chills? _____
 Does your pain keep you from falling asleep? _____ Does your pain ever wake you up from sleep? _____
 Have you lost weight recently without intending to do so? _____ If so, how many pounds? _____
 Have you had any x-ray guided injections? _____ When? _____ Did they help? _____
 Additional Comments: _____