The Dallas Limb
Restoration Center

History of Present Illness – Pain

Circle those that apply to you.

What caused your illness/pain? Disease Accident/Injury Other _____

Describe how and when the pain started _____

_____

Pain Onset: Sudden Gradual **Is the pain?** Constant Intermittent Occasional

Does the pain radiate/shoots: No Yes Where _____

How many hours per day do you have this pain? _____

Does the pain disturb your sleep? No Yes If yes, how many hours do you get per night? _____

What relieves your pain? Heat Ice Massage Nothing Other _____

What makes your pain worse? _____

What activities are most affected by the pain? _____

Rate your pain below: **(No Pain) 1 2 3 4 5 6 7 8 9 10 (Severe)**

Today it is _____ Average Day _____ Good Day _____ Bad Day _____

What diagnostic tests have you had in the last year? X-ray MRI CT EMG Bone Scan Other _____

What treatments have you received in the last year? Physical Therapy Acupuncture Steroid Injections Manipulation
NSAIDS Steroid Pills Muscle Relaxants Pain Medicine

Have you ever had surgery for this problem? No Yes If yes, when _____

Name of doctor and hospital where surgery was performed? _____

Have you had any previous work related injuries? No Yes, when? _____

Is there a lawyer involved in your case? No Yes, whom? _____

PLEASE COMPLETE THIS SECTION IF YOU WERE INJURED ON THE JOB OR IN AN ACCIDENT

Is this a work related injury? No Yes **Is this an accident/injury?** No Yes

Date of Injury: _____ **When did you first notice the pain?** _____

When and Where did you first seek medical help for this? _____

Are you currently working? No Yes ***See below for further questions***

Yes: Full-time _____ Part-time _____ Regular Duty _____ Light Duty _____ How many hours per day? _____

Describe your duties _____

Sitting ____ hours/day Standing ____ hours/day Lifting ____ hours/day Overhead Reaching ____ hours/day

Climbing ____ hours/day Bending ____ hours/day Pushing/Pulling ____ hours/day Repetitive hand movement ____ hours/day

No: How long have you been out of work? _____ Why did you stop working? _____

Have you tried to return to work? No Yes **Are you currently on disability for this injury?** No Yes

If you were injured in an auto accident, were you the: Driver Passenger

Were you? Rear-ended Side-swiped Broad-sided **Were you wearing a seatbelt?** No Yes

Patient Name _____ Today's Date _____