CAPS PAINCARE
Phone: 888-CAPS-313 / 888-227-7313
Fax: 708-632-5602
Email: appt@capspaincare.com
www.capspaincare.com

PATIENT HISTORY FORM A

Today's Date: ______/_______/________ SSN (last 4 digits): xxx-xx - ______

Patient Name: ____ DOB:________________ Age: _________

Sex: ☐Male ☐Female Height:______ Weight:_______ Dominant Hand: ☐ Right ☐ Left

Type of Accident/Injury: ☐Auto ☐Work ☐Personal Injury

Date of Accident/Injury: ________________

HISTORY OF PRESENT ILLNESS

1. What is your main complaint? ____

How long have you had this problem? ______________________________________

What started the problem? ____

2. On the following illustration, mark any other symptoms related to your problem. Does not apply

Use the following symbols

Numbness/Tingling- XXX

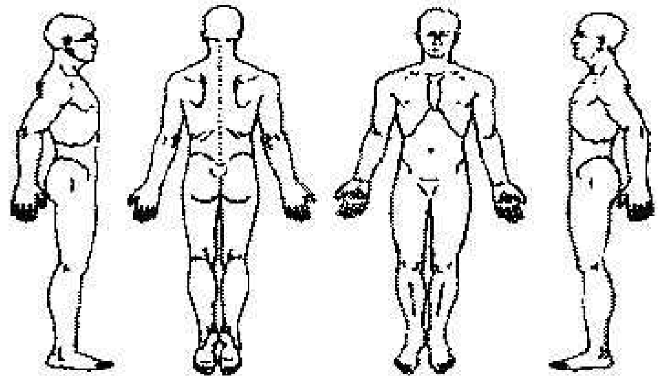
Weakness- OOO

Other Symptoms- +++. List Symptoms Below:

____

____

____



3. For the following questions, check Yes or No. If the answer is yes, indicate the date or time of day.

	Yes	No	If Yes, when and for how long?
Has the problem become worse?	☐	☐	______________
Is this problem the result of a traffic accident?	☐	☐	______________
Is this problem the result of a work accident?	☐	☐	______________
Have you missed any work because of this problem?	☐	☐	______________
Have you stopped working because of this problem?	☐	☐	______________

4. Does anything make your major complaint better? ☐ Yes ☐ No

If Yes, please list (ex: resting/bending)

____

Does anything make your major complaint worse? ☐ Yes ☐ No

If yes, please list (ex: coughing/sneezing/bowel movement)

____

Patient Initials: _________

CAPS PAINCARE
Phone: 888-CAPS-313 / 888-227-7313
Fax: 708-632-5602
Email: appt@capspaincare.com
www.capspaincare.com

PATIENT HISTORY FORM A

5. Have you received physical therapy? ☐ Yes ☐ No
Start and End Dates: ______________________________

Have you received an epidural? ☐ Yes ☐ No Dates: ____________

Have you received an injection? ☐ Yes ☐ No Dates: ____________

6. List all tests that have been performed to evaluate your pain. Please note the test, date, & facility. None
(Ex: X-ray, CT scan, bone scan, MRI, EMG, etc.)

____
____
____
____

7. List all operations, hospitalizations, or injuries None

Year	Type of Surgery	Hospital	Surgeon

PATIENT MEDICAL HISTORY

8. Do you have any of the following? (Check all that may apply) **None apply**

☐ Headaches	☐ Asthma	☐ Alzheimer's
☐ Transplants	☐ Bronchitis	☐ Mental health disorder / Depression / Anxiety
☐ Cancer- Type: ________	☐ Emphysema	☐ Physical / Sexual Abuse
☐ Glaucoma	☐ Peptic Ulcer	☐ Bleeding Disorder
☐ Hearing/Ear Disorder	☐ Kidney Disease/Disorder	☐ Blood Clots in Legs
☐ Esophageal Reflux	☐ Kidney Failure	☐ Sickle Cell Disease
☐ Heart Attack	☐ Liver Disease / Hepatitis	☐ HIV / AIDS
☐ Heart Failure	☐ Gout	☐ Anemia
☐ High or Low Blood Pressure	☐ Osteoporosis	☐ Diabetes
☐ Stroke	☐ Rheumatoid Arthritis	☐ Thyroid Disorder
☐ High Cholesterol	☐ Osteoarthritis	☐ Other: ________
☐ Blood Vessel Disease	☐ Nerve Disease / Disorder	
☐ Rheumatic Fever	☐ Seizure / Epilepsy	
☐ Pneumonia	☐ Sleep Disorder	

Are you pregnant? ☐ Yes ☐ No Last Menstrual Period: ____________

9. Please list ALL CURRENT medications:

MEDICATION NAME	DOSAGE	DATES TAKEN FROM – TO	RESULT	SIDE EFFECTS

If you need more space, please use the back of this page.

Patient Initials: ________

CAPS PAINCARE
Phone: 888-CAPS-313 / 888-227-7313
Fax: 708-632-5602
Email: appt@capspaincare.com
www.capspaincare.com

PATIENT HISTORY FORM A

Please list ALL PAST pain medications taken:

MEDICATION NAME	DOSAGE	DATES TAKEN FROM – TO	RESULT	SIDE EFFECTS	REASON FOR DISCONTINUATION

ALLERGIES ____

FAMILY HISTORY

10. Please indicate if any family member(s) has/had any health issues.

Family History	**Alive or Deceased?**	**Age (s):**	**Any Health Issues? (Diabetes, heart problems, high blood pressure, stroke, etc.)**	**No Health Issue**
Mother:				☐
Father:				☐
Biological Children(#):				☐
Siblings(#):				☐
Extended Family: (Grandparents, Aunts, Uncles, Cousins)	**Any Health Issues?**			☐

REVIEW OF SYSTEMS

11. Are you currently or in the past experienced any of the following? (Circle those that apply)

Constitutional	Unexpected Weight Loss Weight Gain Fever Chills Fatigue
Eyes	Blurring Double Vision Eye Pain Redness Watering Irritation
Ear/Nose/Throat	Earache Ringing in Ears Nose Bleeds Sore Throat Difficulty Swallowing
Cardiovascular	Chest Pain Palpitations Fainting Murmurs
Respiratory	Cough Wheezing Shortness of Breath Inspiration Pain Excessive Sputum
Gastrointestinal	Abdominal Pain Nausea Vomiting Diarrhea Constipation Bloody-tarry stools Heartburn Change in bowel habits Jaundice
Genitourinary	Frequency Urgency Difficulty Controlling Urination Pelvic Pain
Musculoskeletal	Joint Pain Swelling Stiffness Muscle Cramp Muscle Weakness
Skin	Rash Itching Dryness Redness Poor Healing Suspicious Lesions
Neurological	Headache Numbness-Tingling Seizure Tremors Dizziness Weakness
Psychiatric	Depression Anxiety Hallucinations Nervousness Suicidal Thoughts
Hematological	Abnormal Bruising Abnormal bleeding Enlarged Lymph Nodes
Endocrine	Excessive Thirst or Urination Heat-Cold Intolerance Hot Flashes
Allergy	Reactions to Foods or Environment:

Patient Initials: __________

CAPS PAINCARE
Phone: 888-CAPS-313 / 888-227-7313
Fax: 708-632-5602
Email: appt@capspaincare.com
www.capspaincare.com

PATIENT HISTORY FORM A

SOCIAL HISTORY

12. a. Relationship Status
Partnered Divorced Married Widowed Single Separated

b. Do you live alone? Yes No if no, with whom do you live?
Spouse Parents Son/Daughter Other ______________________

c. Do you drink alcohol? Yes No
Rarely Socially Daily Recovering alcoholic

d. Do you smoke now? Yes No since when _____________
How many cigarettes/packs per day? _____; Cigars? _____; Pipe? _____ Quit Smoking; Since ________________

e. Do you use drugs? Yes No
Used drugs in the past Currently use drugs

Do you or have you used illicit or street drugs? Yes No
Marijuana (Date last used) _________ Heroin (Date last used) _________ Cocaine (Date last used)___________
Speed/amphetamines (Date last used) ______________
Other _________________________

Do immediate family members or close associates use illicit drug or participate in drug abuse treatment?
Yes No

f. Have you been treated for substance or alcohol abuse? Yes No
If yes, when? ________________________________ For what substance? ____________________________________
Name and address of facility
____

g. Have you had any legal problems relating to the use of drugs, alcohol, or medication? Yes No

13. What is your current employment status?
Occupation: _______________________________
☐ Employed Full Time ☐ Homemaker ☐ Retired ☐ Student ☐ Unemployed
☐ Employed Part Time ☐ Employed, Modified Duty ☐ Veteran ☐ Disabled

14. Do you have any legal action pending relating to this pain or any other health problem? Yes No

If yes, please list:
Attorney's Name ____
Address ____
Phone ____

15. Are you receiving worker's compensation related to your current injury? Yes No

Patient Initials: _________

16. CERTIFICATION & HEALTH DECISIONS

Patient prefers to make own medical decisions
Medical decisions are made jointly between patient and family
Patient prefers family members to make the major medical decisions

I certify that I have answered all the questions, and have not knowingly withheld any information concerning any of the above problems, either past or present.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Witness Date

THANK YOU FOR YOUR TIME AND ALL YOUR EFFORT!

______________________________ ______________
Signature of Reviewing Physician Date

Patient Initials: __________