# RELATED HISTORY FORM

A. Experience with other medical people or family/friends?
(Ex: Have you seen other doctors? What did they tell you?)

B. How are you coping with pain currently?

C. Do you have any history of a major episode of depression?

D. Current symptoms of depression? Yes No

(Underline appropriate words and explain below)

| | |
|---|---|
| Mood disturbances | Loss of pleasure in activities |
| Feelings of hopelessness | Feelings of worthlessness |
| Low energy | Loss of appetite |
| Sleep disturbance | Thoughts/plans of suicide |

E. Any history of sexual abuse? _____ What ages? _____
By whom? _____

Has anyone ever touched you in any way that made you feel uncomfortable?
_____
What ages? _____ By whom?
_____

Has anyone ever asked you to touch them when you did not want to? _____
What ages? _____ By whom? _____