

*Your First Visit With The Pain Center Physician is a Consultation, You May or May Not Receive an Injection on the First Visit. Thank You.

*Please fill out form completely.

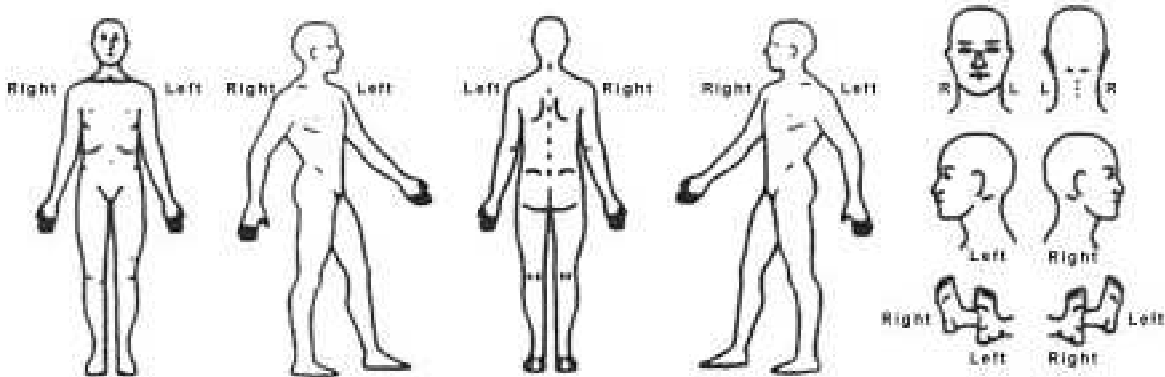
Name: _____ Date of Birth: _____ Age _____

Address _____ Sex: Male _____ Female _____

_____ Home Phone: _____

Referring Physician: _____ Primary Physician _____

Please use the diagram below to mark the areas of your pain.



1. Chief Complaint (main reason for Visit Today)? _____

2. Where is your pain? (Please list most severe First)

A _____ B _____

C _____ D _____

3. When did the pain begin? (Date) _____

4. How did the pain start? /What do you think caused it?

5. Does the pain radiate (travel) anywhere? no, If yes where?



6. On a Scale of 0-10 please indicate (circle) the amount of pain you experience. '0' being no pain at all and '10' being the most severe pain you have ever experienced.

Today: 0 1 2 3 4 5 6 7 8 9 10

The best your pain gets: 0 1 2 3 4 5 6 7 8 9 10

The worst it gets: 0 1 2 3 4 5 6 7 8 9 10

7. Describe what your pain feels like:

- Burning Shooting Throbbing Crushing Dull
 Electrical Sharp Achy Pulling Cramping
 Toothache like Stabbing Hot Numbness Tingling
 Other(describe): _____

8. Please describe the course of your pain during the day:

- Constant Intermittent Constant but varies Hour to Hour and/or Day to day

9. Your pain is worse in the:

- Morning Daytime Evenings Middle of the night Varies

10. What makes the pain worse?

- Sitting Walking Lifting Bending backward
 Standing Driving Laughing Bending forward
 Climbing stairs Straining Sneezing Coughing
 Laying flat Sex Using the bathroom
 Other _____

11. What makes it better?

- Medication Massage Laying down Sitting
 Ice Leaning forward Rest Heat
 Standing Applying Pressure Leaning backward Walking
 Other (Please explain) _____

12. Are there other symptoms with your pain?

- New or progressive weakness Night sweats Dropping things Sweating
 Constipation Headaches Dizziness Fever Chills
 Urinary incontinence Bowel incontinence Urinary retention Numbness
 Other Please explain _____

13. Have you had any of the following over the painful area?

- Swelling Blanching of the skin Light touch causes pain
 Redness Hair or nail changes
 Blue Discoloration Rash

14. Has this problem affected your job? _____

15. How has this problem affected you socially? _____

16. Can you still perform activities of daily living? Yes No? If no please explain _____

17. Is nutrition affected by pain or medications? Yes No

18. Is your sleep disturbed by your pain? Yes No If yes please answer the following?

- I usually go to bed at _____ o'clock.
- I first wake up at _____ o'clock.
- I usually get about _____ hours of sleep.

19. Past treatments for your pain?

Previous Surgery for pain? Please list surgery(s), date(s), Surgeon(s)

Is your pain the same as before surgery or different? _____

20. Have you had pain injections before? Yes No

If yes please list below and dates if known:

- a. _____ d. _____
- b. _____ e. _____
- c. _____ f. _____

21. Have you done Physical Therapy for this pain? Yes No Date of last PT _____

- If yes how many days/week and how many weeks did you do? _____

22. Have you tried:

- | | | |
|---|---|--|
| TENS unit? <input type="checkbox"/> Yes <input type="checkbox"/> No | Biofeedback? <input type="checkbox"/> Yes <input type="checkbox"/> No | Chiropractor? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Brace? <input type="checkbox"/> Yes <input type="checkbox"/> No | Ice/Heat? <input type="checkbox"/> Yes <input type="checkbox"/> No | Massage? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Acupuncture? <input type="checkbox"/> Yes <input type="checkbox"/> No | Meditation <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No |

23. Have you seen anyone else for your pain?

Neurology Rheumatology Physiatrist Orthopedist Neurosurgery

Other pain physician? Etc? Please list _____



24. Are you involved in any litigation or lawsuit regarding your pain? Yes No

25. Are you seeking workman's compensation because of your pain? Yes No

26. Are you on disability? Yes No Reason? _____

Trying to get on disability? Yes No

27. Was the pain result of a Motor Vehicle accident? Yes No

Is there an auto insurance claim? Yes No

Diagnostic Studies for your pain? (circle all that apply and dates and where you got them)

X-ray _____ MRI _____ CT _____

EMG _____ Bone Scan _____ Myleogram _____

Ultrasound _____ Other _____

Social History

Single Married Divorced Widowed Children ___#_____

Occupation/Employer: _____

Status? Full time, Part time, Retired, Unemployed

Smoking Tobacco Yes No Chewing Tobacco Yes No

Marijuana Yes No

Alcohol Yes No

Illegal drugs? If so what type _____ How do you use it? _____

Is there a family history of addiction? Yes No What type? _____

Other: _____

Pharmacy: Name _____ Phone _____

Address _____ City _____ State _____

I, understand, have completed this form. The information that I have provided is true and accurate to the best of my knowledge.

Date Time X Patient/Legal Guardian

X _____
Person signing on patients behalf/relationship Reason patient unable to sign