Pain Interventions
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We would like to welcome you to our office.

For the greatest benefit from your initial evaluation, please note the following:

Complete the enclosed questionnaire to the best of your ability and bring it with you. Although all of the questions may not seem applicable, please complete them as best as you can. This will provide us with information we need to completely evaluate your pain. **Please bring any x-rays, MRIs, CT scans, myelograms, or any reports that may be helpful in evaluating your problem.**

Please bring all insurance and compensation information to your first visit. Depending on your type of health insurance, you may be charged a co-payment. Please bring appropriate payment with you. We accept cash, check or credit card.

If you need to cancel your appointment, please provide us at least 48 hours notice. All cancellations or broken appointments less than 48 hours notice will be charged $40.00.

*We appreciate your consideration in helping us provide quality care. If you have special needs or circumstances, please discuss them with us. We look forward to meeting you.*

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Last Name_____ First Name _____ Middle Initial _____

Primary Care Physician: _____Referring Physician: _____

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Where is your pain? _____

When did you first notice your pain? (Date) _____

**How did your pain begin?**

___ Accident at work ___ Accident at home ___ At work, not an accident

___ Pain just began/No reason ___ Motor Vehicle Accident ___ Following surgery

___ Other _____

If Worker's Comp or No Fault please describe the incident in detail: _____

_____

_____

When is your pain the worst? ____ Morning ____ Afternoon ____Evening ____ Night

Does the pain interrupt your sleep? ____ No ____ 1-2 X night ____3 or more X night

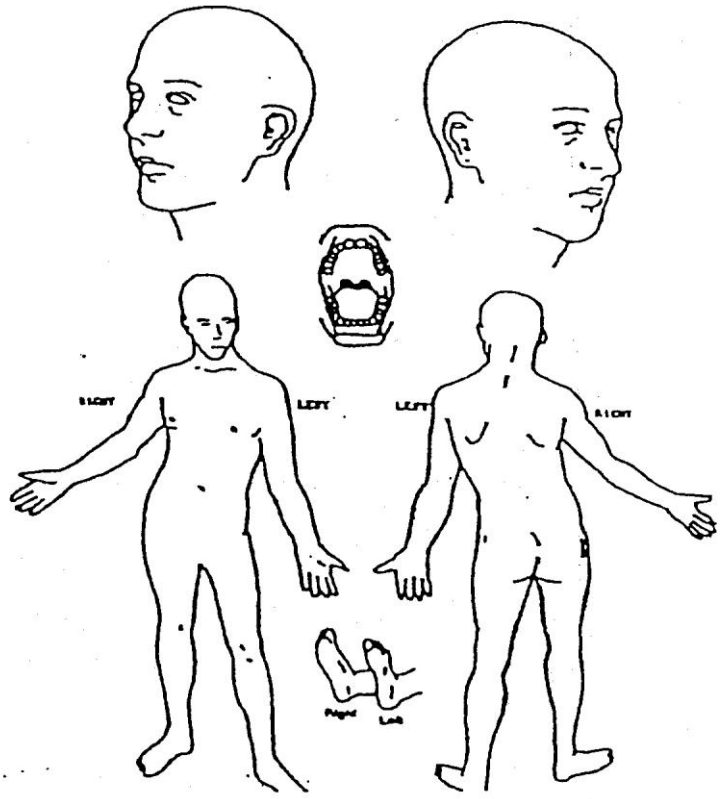
Do you have any numbness? (where) _____

Do you have any weakness? (where) _____

Please circle the words that describe your pain.

| | | | | | |
|---|---|---|---|---|---|
| Achy | Burning | Dull | Excruciating | Numb | Pounding |
| Sharp | Shooting | Stabbing | Stinging | Throbbing | Other: _____ |

**PLEASE SHADE IN THE AREAS YOU HAVE PAIN**



RATE YOUR PAIN INTENSITY

Your pain at its most severe is a: (circle a number)

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| no pain | | | | | | | | | | worst pain imaginable |

Your pain at its least severe is a: (circle a number)

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| no pain | | | | | | | | | | worst pain imaginable |

What makes your pain worse? _____

_____

What makes you pain less severe? _____

_____

Overall, since the pain began, it has: _____ Increased _____ Decreased _____Stayed the same

Previous treatments for pain:

| | (Check) | (Date) | Helpful? | | (Check) | (Date) | Helpful? |
|---|---|---|---|---|---|---|---|
| Physical Therapy | _____ | _____ | _____ | Water based PT | _____ | _____ | _____ |
| TENS unit | _____ | _____ | _____ | Chiropractor | _____ | _____ | _____ |
| Acupuncture | _____ | _____ | _____ | Massage therapy | _____ | _____ | _____ |
| Counseling | _____ | _____ | _____ | Biofeedback/Relaxation | _____ | _____ | _____ |
| Nerve Blocks | _____ | _____ | _____ | Injections | _____ | _____ | _____ |

Have you ever been treated by another Pain Center? ____ Yes ____ No

If yes, list names of physicians, centers, dates, and types of treatment.

_____

List all tests you have had to evaluate your pain::

| | When | Where | | When | Where |
|---|---|---|---|---|---|
| X-rays: | _____ | _____ | MRI: | _____ | _____ |
| CAT scan: | _____ | _____ | Myelogram: | _____ | _____ |
| Bone scan: | _____ | _____ | NCS/EMG: | _____ | _____ |
| Vascular: | _____ | _____ | Other: | _____ | _____ |

List all medical problems you currently have: _____

_____

Have you ever had problems with the following conditions? (Please check).

Neurological:
___ Dizziness
___ Headaches
___ Seizures
___ Stroke
___ Blackouts
___ Falling/tremors

Circulatory:
___ chest pain/angina
___heart attack
___ irregular heart beat
___high blood pressure
___ vascular disease
___ blood clot/phlebitis

Respiratory:
___ asthma.
___ emphysema.
___chronic bronchitis.
___ chronic cough.
___ tuberculosis.
___lung cancer.

Gastrointestinal:
___ Hepatitis
___ Gerd/reflux
___ Hiatal hernia
___ Ulcer
___ Diverticulosis
___ Constipation
___ Irritable bowel
___ Crohn's disease

Endocrine:
___ diabetes
___ thyroid

GU/GYN:
___ sexual dysfunction
___ pelvic pain
___ kidney disease/stones
___ prostate disease

Immune/Rheumatologic:
___ osteoarthritis.
___ rheumatoid arthritis.
___ polymyalgia rheumatica.
___lupus.
___ neck/back pain.
___ HIV/AIDS.

Psychological:
___ Depression
___ Anxiety
___ Suicidal Thoughts

Constitutional:
___ Weight Gain
___ Weight Loss
___ Insomnia

___ Persistent Irritability
___ Alcohol or Drug Addiction
___ Other: _____

other: _____ cancer of: _____

Skin disorder: _____

Are you sexually active? _____ Yes _____ No **Are you pregnant**? _____ Yes _____ No.
Do you have glaucoma? _____ Yes _____ No

Family History of :

_____

_____

List all operations you have had in your lifetime and the **dates:**

Operation: Date: Operation: Date:

_____ _____

_____ _____

_____ _____

**LIST ALL OF YOUR CURRENT MEDICATIONS *INCLUDING DOSAGES***

Please include all non-pain medications, herbal remedies, and over the counter medications.

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

LIST ALL OF YOUR **PREVIOUS** PAIN MEDICATIONS: _____

_____

List all of your medication **allergies**: _____

Check the substances that you are using or have used in the past:

_____ Alcohol Currently using? ___ Yes ___ No ____ Never How much per day? _____

_____ Tobacco Currently using? ___ Yes ___ No ____ Never How much per day? _____

Please check any substances you have used:

_____ Marijuana _____ Cocaine/crack _____ Amphetamines/speed _____ Barbiturates/Downers

_____ Ecstasy _____ Heroine Currently using any of the above? ___ yes ___ no

_____ Painkillers **not** prescribed for you. And what medicine? _____

Have you ever participated in a substance abuse treatment program? ____ Yes ____ No

If so, when and for what substances? _____

Marital status: _____Married _____Divorced _____Separated _____Single _____Widowed
Now living with: _____Spouse _____Children ____Parent(s) _____Other _____Alone

EDUCATION (check highest level completed):

_____Less than 8th grade _____some high school _____high school graduate
_____ some college _____4-year college graduate _____postgraduate degree.

EMPLOYMENT HISTORY

Are you working now? _____ Yes _____ No Numbers of hours per week: _____

Job description/position: _____

Check if retired _____ Check if unemployed _____

If your pain is work-related please answer the following:

What is the last day worked? _____

Is your present/previous job being held for you? _____ Yes _____ No.

Do you now receive compensation or disability payments? _____ Yes _____ No.

Have you ever been through a work hardening or vocational retraining program?

_____ No _____ Yes Describe: _____

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**(DO NOT FILL BELOW)**

Ht: _____ Wt: _____ BP: _____/_____ HR: _____ RR: _____