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 $100.00.

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.

Last Name_____ First Name _____ Middle Initial _____

Primary Care Physician: _____

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(MVA) 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

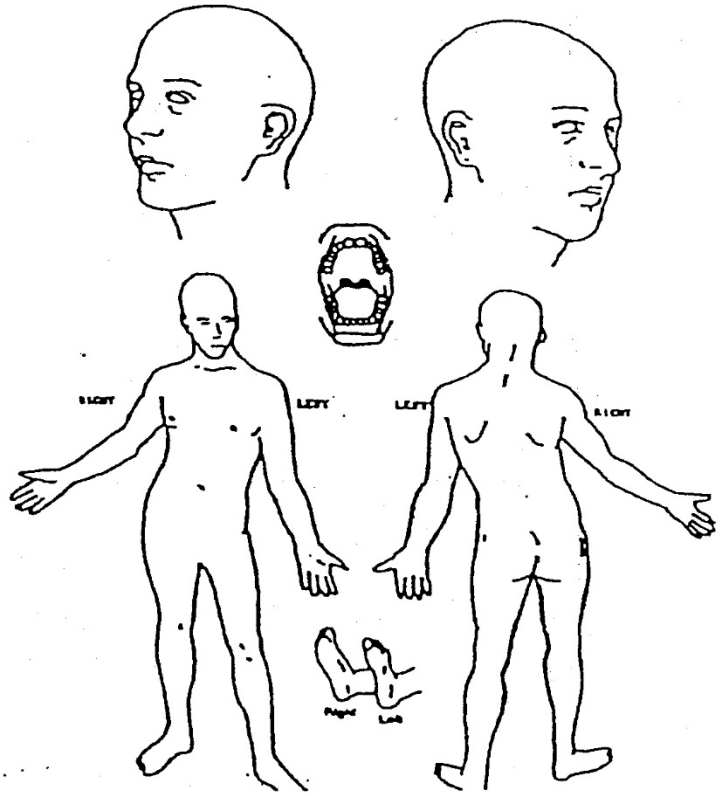
Do you have any numbness? (where) _____

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	

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 your pain less severe? _____

_____

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

Previous treatments for pain:

	(check)	Helpful?		(check)	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 pregnant? _____ Yes _____ No.
Do you have glaucoma? _____ Yes _____ No

FAMILY HISTORY

___ Diabetes ___ Hypertension ___ Cancer ___ Heart Disease

List Other :_____

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 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 How much per day? _____

_____ Tobacco Currently using? ___ yes ___ no How much per day? _____

_____ Marijuana Currently using? ___ yes ___ no How much per day? _____

Please check any substances you have used:

_____ 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: _____

(DO NOT FILL BELOW)

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