

DATE: _____

Please read these sheets carefully and answer **ALL QUESTIONS** to the best of your ability. They will assist us in better treating your pain. Thank you for your time and cooperation.

NAME: _____

LAST

FIRST

MIDDLE

HEIGHT

WEIGHT

AGE

Who is your Primary Care Provider? _____

Who is your Referring Doctor? _____

WHERE IS MOST OF YOUR PAIN TODAY / WHY ARE YOU COMING TO OUR OFFICE, TODAY? (We realize that many of our patients may have multiple sites of pain, or are being referred for one particular type of pain. Therefore, in order to better serve you, and to try and provide you with the best results possible, we can only concentrate on one area at a time before moving to other areas of your body). Please indicate on the diagram below using the symbols to describe the type of pain to that area. Mark the area to where the pain radiates, with using arrows. More than one type of symbol may be necessary—we understand that this may be the case.

ACHING NUMBNESS PINS & NEEDLES BURNING STABBING

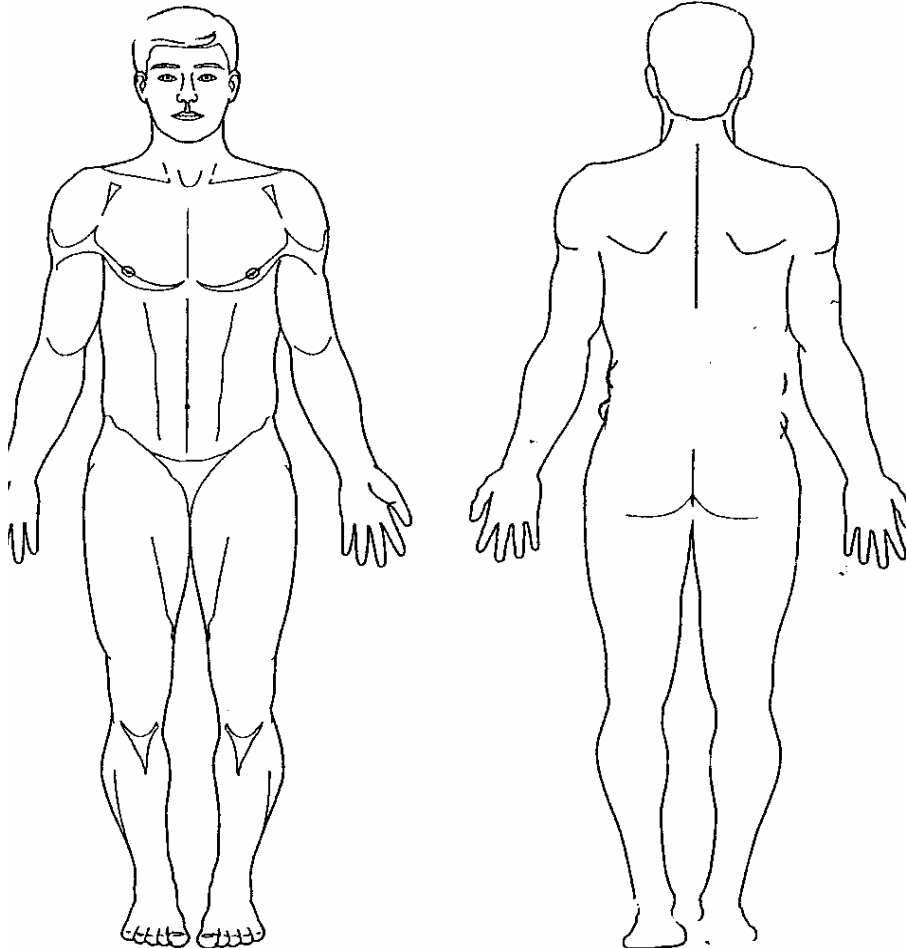
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NAME: _____ DATE: _____

DURATION

How long have you had this pain? What was the date of your injury? _____

What do you believe is the cause of your pain? _____

Is it constant or does the pain come-and-go _____

AGRAVATING/ALLEVIATING FACTORS

Please (√) indicate if the following increases or decreases your pain.

	INCREASES	DECREASES
LIQUOR		
STIMULANTS (COFFEE, ETC.)		
EATING		
COLD		
DAMP		
WEATHER CHANGES		
PHYSICAL ACTIVITY		
MASSAGE		
PRESSURE		
MOVEMENT		
SLEEP OR REST		
LYING DOWN		
SITTING		
SEXUAL INTERCOURSE		
STANDING		
DISTRACTION (TV, CRAFTS, ETC.)		
URINATION		
BOWEL MOVEMENT		
TENSION		
BRIGHT LIGHTS		
LOUD NOISES		
FATIGUE		
SNEEZING/COUGHING		
RIDING IN A CAR		
WALKING		

DAILY FUNCTIONINGCircle the numbers below that best describe how pain has interfered with your daily functioning.
(0=Does not interfere, 10=Interferes greatly)

General Activity	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Walking Ability	0	1	2	3	4	5	6	7	8	9	10
Normal Work Routine	0	1	2	3	4	5	6	7	8	9	10
Relations with Other People	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10
Ability to Concentrate	0	1	2	3	4	5	6	7	8	9	10
Appetite	0	1	2	3	4	5	6	7	8	9	10

NAME: _____ DATE: _____

PAIN SCALE

Use the following rating scales to indicate how severe your pain is. Circle the appropriate number with 1 being least and 10 being the worst. There is **no pain greater than 10**. Remember, 10 is the most severe pain possible. (For example, being on fire, while completely awake).

Your pain at its WORST :	0	1	2	3	4	5	6	7	8	9	10
Your pain at its LEAST severe:	0	1	2	3	4	5	6	7	8	9	10
Your pain on AVERAGE :	0	1	2	3	4	5	6	7	8	9	10
Your pain at the PRESENT TIME :	0	1	2	3	4	5	6	7	8	9	10
What level of pain do you think you could function with on a daily basis?	0	1	2	3	4	5	6	7	8	9	10

PRIOR TREATMENTS

Please check any of the following treatments you have had for this pain problem. Include any dates and results. (√) Check all that apply.

	Improved	Not Improved
Nerve Block		
Epidural Steroid		
TENS Unit		
Physical Therapy		
Traction		
Acupuncture		
Chiropractor		
Psychiatrist/Psychologist		
Hypnosis/Biofeedback		
Alternative Medical Treatments		
Other Pain Clinic		
Surgery		
Other		

ALLERGIES

Do you have any allergies to any medications? If so, please list which ones and the **exact** type of reaction you have.

Do you have any allergies to any foods, including shellfish or strawberries?

Are you allergic to Latex, iodine, or IVP dye?

SURGERY

Please list all surgeries you have had and the year.

SURGERY	YEAR

NAME: _____ DATE: _____

Please list any MEDICAL CONDITIONS you currently have and any illnesses or conditions for which you have been hospitalized. (i.e. osteoarthritis, hypertension, colitis, bipolar disorder, heart attack, seizure, asthma, etc.)

Please answer **ALL** of the following questions. If the item does not apply to you, then mark it NO. We try to take the entire person into consideration, when treating pain—this includes treating the psychological aspect of pain. In order for us to adequately address this area and the needs of these patients, it is necessary for us to have a basic, beginning amount of information on *everyone*. Please answer truthfully and completely. *Omissions and untruthful responses don't allow us to offer you all benefits one might need for proper healing.*

ALCOHOL USE

How much beer/alcoholic beverages do you drink?

Daily? _____ Weekly? _____ Monthly? _____

I drink: socially very infrequently (less than monthly) do not drink

ALTERNATIVE MEDICINE

What treatments have you sought to help with pain:

- Vitamin Supplements Mineral Supplements Herbal Supplements
- Acupuncture Aroma Therapy Chelation Therapy
- Homeopathic Treatments Massage Therapy Naturopathic Treatment
- Oriental Medicine

Are the treatments still ongoing? YES NO

AUTOMOBILE TYPE

Do you drive? YES NO

What type of automobile do you drive? AUTOMATIC OR MANUAL

If NO, what is the reason for not driving? _____

CAFFEINE USE

How many caffeinated beverages do you drink per day?

- 1-2 / day 3-5 / day 6-9 / day NONE

EDUCATION LEVEL

What level of education do you have?

- High School/GED Some College/Associate Degree Bachelor's Degree
- Only Some High School Professional Degree Master's Degree

EMPLOYMENT

Are you currently employed? YES NO

Occupation / Reason for Non-employment _____

ILLEGAL DRUG USE

Do you use or have you ever used illegal drugs:

- Marijuana Cocaine Crack Crank Ecstasy
- Heroin Inhalants LSD PCP Methamphetamines

If yes, which drugs do you currently use? _____

Are you currently in/have you ever attended a substance abuse program? YES NO

NAME: _____ DATE: _____

LITIGATION

Is your pain the result of an accident or injury? YES NO

Is there litigation pending? YES NO

Is there a history of litigation in the past? YES NO

Who is your attorney? _____

MARITAL STATUS

Married Single Divorced Widowed

CHILDREN

How many children do you have? _____

MENTAL HEALTH HISTORY

Have you sought substance abuse treatment in the past? YES NO

Have you ever attempted suicide in the past? YES NO

Have you been hospitalized for any other psychiatric illness? YES NO

If you answered YES to any of these questions, please explain below: _____

PRESCRIPTION DRUG ABUSE

Have you ever been found abusing prescription medications, such as amphetamines, benzodiazepines, barbiturates, codeine, Demerol, or morphine? YES NO

SLEEP HABITS

Do you sleep on a:

Traditional Mattress Waterbed Airbed Floor Couch or Chair

Do you have difficulty falling asleep? YES NO

Do you have difficulty staying asleep? YES NO

Do you require medication to fall asleep? YES NO If yes, what: _____

Do wake in the morning feeling rested or still feeling tired? (Check one)

Does the pain interrupt your sleep? YES NO

If yes, how many time(s) does it awaken you? 1 2 3

TOBACCO USE

Do you smoke? YES NO

If yes, how many packs a day do you smoke? _____

How many years have you smoked? _____

NAME: _____ DATE: _____

PLEASE CHECK THE BOX NEXT TO THE CONDITIONS, WHICH YOU HAVE EVER EXPERIENCED.

- | | | |
|---|---|---|
| <input type="checkbox"/> Abdomen pain | <input type="checkbox"/> Flank pain/pain in kidney area of low back | <input type="checkbox"/> Psychiatric or emotional difficulties |
| <input type="checkbox"/> Abdominal aortic aneurysm | <input type="checkbox"/> Focal weakness | <input type="checkbox"/> Racing heart |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> Rape or sexual abuse victim |
| <input type="checkbox"/> Addiction to alcohol | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Addictive tendencies | <input type="checkbox"/> Groups of vesicles noted | <input type="checkbox"/> Rash, petechiae |
| <input type="checkbox"/> Admission to psychiatric facility | <input type="checkbox"/> Headache | <input type="checkbox"/> Recent rape or sexual abuse |
| <input type="checkbox"/> Allergic or immunologic symptoms | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Recent seizure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hematuria | <input type="checkbox"/> Recent sickle cell crisis |
| <input type="checkbox"/> Anesthesia/areas of skin without feeling | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> Angry feelings | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Renal failure/non-functioning kidney |
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Scoliosis/crooked spine |
| <input type="checkbox"/> Anxious feelings | <input type="checkbox"/> Herpes outbreak now or recently | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Arrhythmias/abnormal heart beat | <input type="checkbox"/> Herpes zoster currently | <input type="checkbox"/> Seizure history |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herpes zoster in past | <input type="checkbox"/> Shortness or breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Sinus congestion |
| <input type="checkbox"/> Aura, olfactory | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Aura, visual | <input type="checkbox"/> Hypersensitivity of skin | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Impotence | <input type="checkbox"/> Stent/to artery in heart or other vessel |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Incontinence of stool | <input type="checkbox"/> Stiffness in AM |
| <input type="checkbox"/> Blisters | <input type="checkbox"/> Increased time to stop bleeding | <input type="checkbox"/> Stocking and glove numbness |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Breathing difficulties, respiratory symptoms | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Cephalgia/headaches | <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Swollen lymph nodes |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Lupus | <input type="checkbox"/> Symptoms involving ear, nose, mouth, or throat |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Syncope/fainting spells |
| <input type="checkbox"/> Current need for kidney dialysis | <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Muscle tenderness | <input type="checkbox"/> Tingling sensation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Myasthenia gravis | <input type="checkbox"/> Temporary loss of vision |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nausea and vomiting | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Difficulty falling off to sleep | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Valve problems, in heart |
| <input type="checkbox"/> Diplopia/double vision | <input type="checkbox"/> Non-healing wound | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Dribbling | <input type="checkbox"/> Oxygen use | <input type="checkbox"/> Weight loss, intentional |
| <input type="checkbox"/> Emotional or mental abuse | <input type="checkbox"/> Pain or soreness in or about the eyes | <input type="checkbox"/> Weight loss, unintentional |
| <input type="checkbox"/> Epigastric pain | <input type="checkbox"/> Peripheral vascular disease (poor blood flow in lower extremities) | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Photosensitivity | <input type="checkbox"/> Yellow sclera/yellowing of white part of eye |
| <input type="checkbox"/> Excessive scar tissue | <input type="checkbox"/> Point tenderness | <input type="checkbox"/> Yellowing of skin |
| | <input type="checkbox"/> Previous myocardial infarction/heart attack | |

NAME: _____ DATE: _____

Indicate which of the following medications you have taken in the past for you pain. If a particular medication is not found in the table, write it on the lines provided at the end of this sheet.

Narcotics / Opioids

- Buprenorphine (Buprenex)
- Butorphanol (Stadol nasal spray)
- Codeine (Tylenol #3)
- Fentanyl (Duragesic Patch)
- Hydrocodone (Vicodin, Lortab)
- Hydromorphone (Dilaudid)
- Levorphanol (Levo-Dromerol)
- Meperidine (Demerol)
- Methadone (Dolophine)
- Morphine (MS Contin)
- Nalbuphine (Nubaine)
- Oxycodone (Percocet, Oxycontin)
- Oxymorphone (Numorphan)
- Pentazocine (Talwin)
- Propoxyphene (Darvocet, Wygesic)
- Tramadol (Ultram)

Muscle Relaxants / Antispasmodics

- Baclofen (Lioresal)
- Carisoprodol (Soma)
- Chlorzoxazone (Parafon Forte)
- Cyclobenzaprine (Klonopin)
- Metaxalone (Skelaxin)
- Methocarbamol (Robaxin)
- Orphenadrine (Norflex, Norgesic)

Non-steroidal/Anti-Inflammatory Agents

- Aspirin
- Celecoxib (Celebrex)
- Diclofenac Potassium (Cataflam)
- Diclofenac sodium (Voltaren)
- Etodolac (Lodine)
- Fenoprofen (Nalfon)
- Flurbiprofen (Ansaid)
- Indomethacin (Indocin)
- Ketoprofen (Orudis)
- Ketorolac (Toradol)
- Meclufenamate

- (Meclomen)
- Nabumetone (Relafen)
- Naproxen (Aleve, Anaprox, Naprosyn)
- Oxaprozin (Daypro)
- Piroxicam (Feldene)
- Sulindac (Clinoril)
- Tolmetin (Tolectin)

Pain Relief Adjuncts / Sleep Aids / Anti-depressants

- Amitriptyline (Elavil)
- Bupropion (Wellbutrin, Zyban)
- Citalopram (Celexa)
- Desipramine (Norpramin)
- Doxepin (Sinequan)
- Fluoxetine (Prozac)
- Fluvoxamine (Luvox)
- Imipramine (Tofranil)
- Mirtazapine (Remeron)
- Nefazodone (Serzone)
- Nortriptyline (Pamelor)
- Paroxetine (Paxil)
- Sertraline (Zoloft)
- Trazadone (Desyrel)
- Venlafaxine (Effexor)

Pain Relief Adjunct / Anti-convulsant Medications

- Carbamazepine (Tegretol)
- Gabapentin (Neurontin)
- Phenytoin (Dilantin)
- Valproic Acid (Depakote)

Migraine Medications

- Acetaminophen (Tylenol)
- Butalbital (Esgic, Fioricet, Fiorinal, Phrenilin)
- Ergotamine ± Caffeine (Caregot, Wigraine, Ercaf, Ergostat)
- Dihydroergotamine (D.H.E. 45 injection, Migranal NS)
- Isometheptent/ Dichloralphenazone / Acetaminophen (Midrin)
- Methysergide (Sansert)
- Propranolol (Inderol)
- Naratriptan (Amerge)
- Rizatriptan (Maxalt)
- Sumatriptan (Imitrex, Nasal spray or tablets)

- Zolmitriptan (Zomig)

Steroid Therapy

- Dexamethasone (Decadron)
- Methylprednidolone (Medrol Dosepak)
- Prednisone
- Cortisone Injections

Anti-anxiety Medications

- Alprazolam (Xanax)
- Diazepam (Valium)
- Lorazepam (Ativan)
- Oxazepam (Serax)

Sleep Aids

- Diphenhydramine (Benadryl)
- Flurazepam (Dalmane)
- Hydroxyzine (Atarax, Vistaril)
- Prochlorperazine (Compazine)
- Promethazine (Phenergan)
- Temazepam (Restoril)
- Triazolam (Halcion)
- Zolpidem (Ambien)

Topical Agents

- Lidocaine / Prilocaine (EMLA cream)
- Capsaicin (Zostrix)

Natural Medicines

- Hypericum (St. Johns Wart)
- Melatonin
- Valerian
- Feverfew
- Kava Kava
- Ginseng
- Ginseng
- Echinacea
- Ma Huang (Ephedra)
- Ginko Biloba
- Saw Palmetto

Other

NAME: _____

DATE: _____