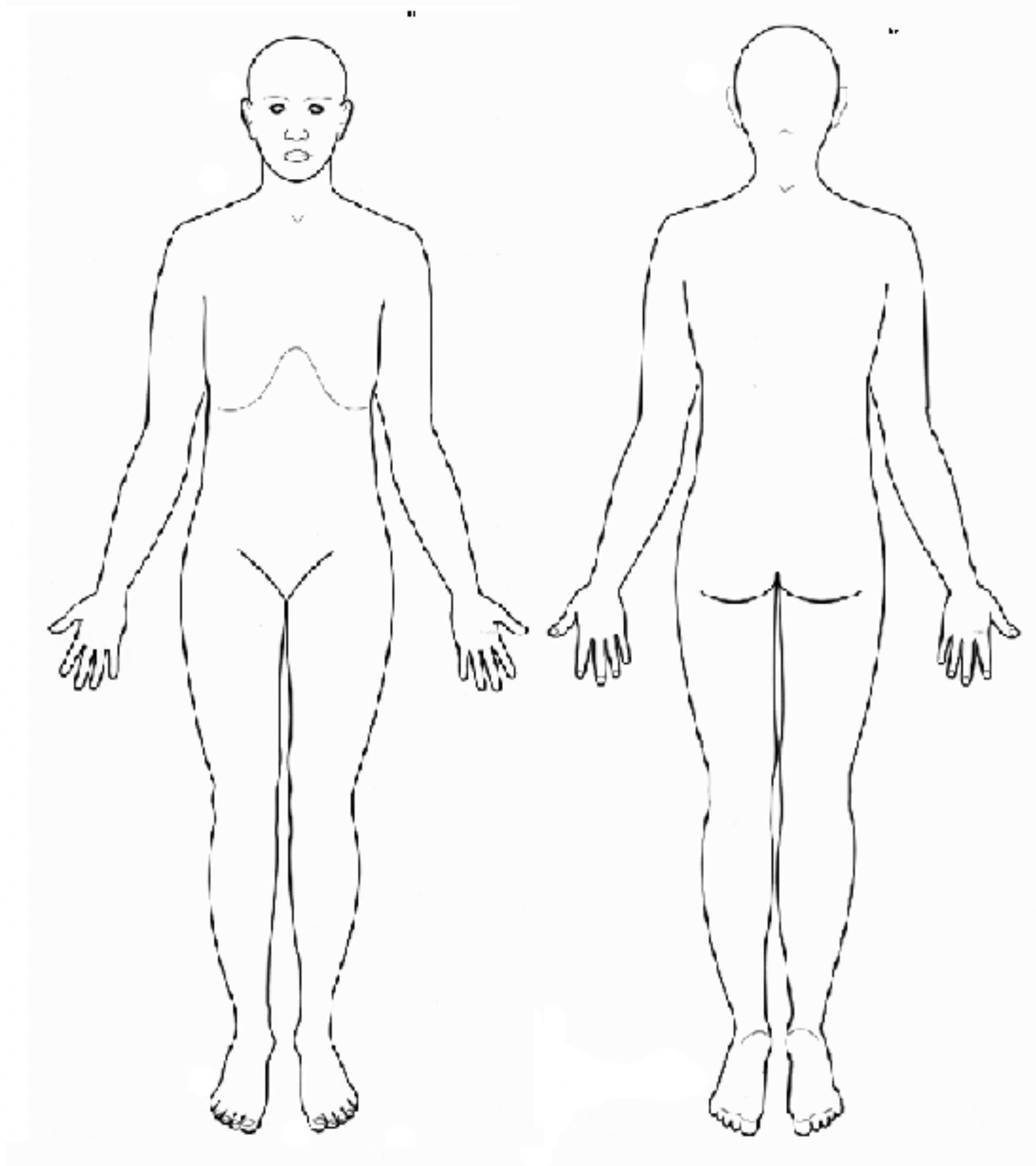
This form must be filled out and brought with you the day of your appointment. It is critical for your referral to our clinic and to ensure proper insurance billing.

PLEASE USE BLACK OR BLUE INK ONLY. **DO NOT USE PENCIL OR HIGHLIGHTERS**

Patient Name: ______________________________ **Date of Birth:** ______________

Appt Date: ______________________ **Age:** __________ **Wt:** __________ **Ht:** __________

PLEASE SHADE IN THE AREA WHERE YOUR PAIN IS LOCATED THAT WE ARE TREATING YOU FOR



Where is your chief complaint of pain located: (circle your answer)

Entire body	Head	Face	Headache
Neck	Chest	RUQ/abdomen	RLQ/abdomen
LUQ/abdomen	LLQ/abdomen	Left groin	Right groin
Left shoulder	Right Shoulder	Right arm	Left arm
Upper back	Mid-back	Lower back	Sacral
Left buttock	Right buttock	Left leg	Right leg

Does your pain radiate anywhere? If so, where? ____________________________________

____

____

When did the pain/injury begin (Date of Injury of Accident)? _________________________

Work Comp Injury: Y__ N__ **Motor Vehicle Accident**: Y__ N__ **Litigation**: Y__ N__

Description of pain: (Circle all that apply)

Aching Burning Constant Cramping Dull Gnawing Heavy
Improving Intermittent Sharp Shooting Soreness Splitting
Stabbing Stable Stiffness Tender Throbbing Worsening

What makes your pain worse: (Circle all that apply)

Bending forward Bending Backward Bending to the side Coughing/Sneezing
Damp weather Driving Exercising Going up/down stairs Heat Housework
Lifting Lying down Medications Neck rotation/movement Nerve Block
Injections Nothing Overhead activity Physical Therapy Physical Activity
Resting Sexual Activity Sitting Standing Stress Walking Yard-work
Getting up from a sitting position Touch/clothing

What makes your pain better: (Circle all that apply)

Doing nothing Bending forward Bending Backward Bending to the side
Coughing/Sneezing Biofreeze gel Damp weather Driving Exercising
Frequent position changes Going up/down stairs Heat Hot tub Housework
Ice Lifting Lying down Medications Massage Neck rotation/movement
Nerve Block Injections Nothing Overhead activity Physical Therapy Physical
Activity Resting Sexual Activity Sitting Standing TENS Unit

Do you have the following: (Check all that apply)

___Numbness
___Tingling
___Pins and needles
___Weakness
___Coldness
___Swelling
___Increased hair growth
___Decreased hair growth
___Shiny, thin skin
___Problems with bowel related to pain
___Problems with bladder related to pain
___Muscle spasms in the neck
___Muscle spasms in the lower back
___Fatigue
___Difficulty Sleeping

When your pain is at its worst, how do you rate it on scale of 0 (no pain) to 10 (worst pain you can imagine): ________

When your pain is at its least, how do you rate it? ________

What is your current pain level? _________

Which statement best describes your pain: (Circle One)

Always present and always has the same intensity

Always present and the intensity varies

Usually present but have short periods without pain

Often present but have pain free periods

Often present but am pain free for most of the day

Occasionally present but have pain one to several times a day lasts few minutes to 1 hour

Rarely present but have pain every few days or weeks

What time of day is your pain the worst: (Circle One)

In the morning on arising

Later in the morning

In the afternoon

At bedtime

At night (usually during sleeping hours)

In the evening

The pain varies, but is not worse at any particular time

The pain is always at its worst

Since your pain began has it: Increased_____ Decreased _____ Stayed the same______

Have you been hospitalized for your pain? If so, what hospital and when?______________

____

Approximately how many Emergency Room visits have you had in the last year for your pain?
____0 ____1-5 ____6-10 ____10-20 ____20-30

When coping with your pain, are you feeling:

____Depressed ____Angry

____Frustrated ____Hopeless

Have you ever been to another pain clinic? If so, where and when?__________________ __

____

Have you had an MRI of the area of interest? ____ Yes ____ No
If yes, where was it taken? ____

Previous Treatment: (Check all that apply and indicate if it helped)

	Therapy	Did it help? (Yes or No)
	Aquatic Therapy	
	Biofeedback	
	TENS Unit	
	Acupuncture	
	Chiropractor	
	Myofascial Release	
	Traction	
	Psychiatric Therapy	
	Occupational Therapy	
	Physical Therapy	
	Trigger Point Therapy	

Previous Medications: (Check all that apply and indicate if it helped)

	Type of Medication	Did it help? (Yes or No)
	Opioids (Lortab, Hydrocodone, Darvocet, etc.)	
	Antidepressants (Cymbalta, Effexor, etc.)	
	NSAIDS (Ibuprofen, Aleve, Celebrex, etc.)	
	Anti-convulsant (Topamax, Lyrica, Neurontin,etc)	
	Muscle Relaxers (Flexeril, Zanaflex, etc.)	
	Oral Steroids (Prednisone)	

Have you ever had a nerve block injection? If so, what type and how any?______________

____

Does pain keep you from taking part in social or recreational activities? If so, what can't you do that you would like to do?____

____

How many hours of sleep, even if interrupted, do you get in a 24 hr period? __________

Prior to the initial onset of your pain, how many hours of sleep did you get in a 24 hr period? _________

What are your expectations for today's visit? ____

____

____

Surgeries:

Date	**Surgical Procedure**	**Surgeon's Name**
______________	______________________________	________________________
______________	______________________________	________________________
______________	______________________________	________________________
______________	______________________________	________________________
______________	______________________________	________________________

Do you have any illnesses or diagnoses, such as high blood pressure, high cholesterol, diabetes, anxiety, depression, etc? If so, what? ______________________________________

____

Is your family history significant for anything (i.e. High blood pressure, high cholesterol, heart disease, cancer, etc.)?____

____

Marital Status: (Circle One)

Single Married Widowed Divorced

# of Children:____

Do you smoke? If so, how many packs per day and for how many years? _______________

____

Do you drink alcohol? If so, how much and how often? ______________________________

Are you currently employed: ____Yes ____No

Place of Employment: ____

Position/Type of Work: ____

Retired: ____Yes ____No Disabled: ____Yes ____No

Last day of Employment: ____

Personal or family history of drug or alcohol abuse: ___________________________

____

____

Referring Physician: ____

Family Physician: ____

Medication	Dosage	Frequency

What pharmacy do you use? ____

Location/Address: ____

Do you have any allergies: (Please list the allergy and reaction)**:**__________________________

____

____

Review of Systems:

General:
Y__ N__ Fever
Y__ N__ Chills
Y__ N__ Sweats
Y__ N__ Decreased appetite
Y__ N__ Fatigue
Y__ N__ Weight loss

Eyes:
Y__ N__ Blurring
Y__ N__ Double Vision
Y__ N__ Irritation
Y__ N__ Discharge
Y__ N__ Vision Loss
Y__ N__ Eye Pain
Y__ N__ Light sensitivity

Ear/Nose/Throat:
Y__ N__ Earache
Y__ N__ Ear discharge
Y__ N__ Ringing in ears
Y__ N__ Hearing Loss
Y__ N__ Congestion
Y__ N__ Nose bleeds
Y__ N__ Sore throat
Y__ N__ Hoarseness
Y__ N__ Difficulty swallowing

Cardiovascular:
Y__ N__Chest pains
Y__ N__ Palpitations
Y__ N__ Fainting
Y__ N__ Difficulty breathing with activity
Y__ N__ Difficulty breathing lying flat
Y__ N__ Sleep apnea
Y__ N__ Swelling in feet/ankles/hands

Respiratory:
Y__ N__ Cough
Y__ N__ Difficulty breathing
Y__ N__ Excessive sputum
Y__ N__ Coughing up blood
Y__ N__ Wheezing

Gastrointestinal:
Y__ N__ Nausea
Y__ N__ Vomiting
Y__ N__ Diarrhea
Y__ N__ Constipation
Y__ N__ Change of bowel habits
Y__ N__ Abdominal pain
Y__ N__ Black/tarry stools
Y__ N__ Blood in stools
Y__ N__ Jaundice

Genitourinary:
Y__ N__ Difficult/Painful urination
Y__ N__ Blood in urine
Y__ N__ Discharge
Y__ N__ Urinary frequency
Y__ N__ Urinary hesitancy
Y__ N__ Urinary urgency
Y__ N__ Night urination
Y__ N__ Incontinence
Y__ N__ Abnormal vaginal bleeding
Y__ N__ Pelvic pain
Y__ N__ Genital sores
Y__ N__ Impotence
Y__ N__ Decreased libido

Musculoskeletal:
Y__ N__ Back pain
Y__ N__ Joint pain
Y__ N__ Joint swelling
Y__ N__ Muscle cramps
Y__ N__ Muscle weakness
Y__ N__ Stiffness
Y__ N__ Arthritis

Skin:
Y__ N__ Rash
Y__ N__ Itching
Y__ N__ Dryness
Y__ N__ Suspicious lesions

Neurologic:
Y__ N__ Transient paralysis
Y__ N__ Weakness
Y__ N__ Pins and needles feeling
Y__ N__ Seizures
Y__ N__ Fainting
Y__ N__ Tremors
Y__ N__ Dizziness

Psychiatric:
Y__ N__ Depression
Y__ N__ Anxiety
Y__ N__ Memory loss
Y__ N__ Mental disturbance
Y__ N__ Suicidal thoughts
Y__ N__ Hallucinations
Y__ N__ Paranoia

Endocrine:
Y__ N__ Cold intolerance
Y__ N__ Heat intolerance
Y__ N__ Intense thirst
Y__ N__ Excessive eating
Y__ N__ Excessive urination
Y__ N__ Weight change

Heme/Lymphatic
Y__ N__ Abnormal bruising
Y__ N__ Bleeding
Y__ N__ Enlarged lymph nodes

Allergic/Immunologic:
Y__ N__ Hives
Y__ N__ Hay fever
Y__ N__ Persistent infections
Y__ N__ HIV exposure

Ambulation Aids:
Y__ N__ Cane
Y__ N__ Walker
Y__ N__ Wheelchair

Oswestry Questionnaire:
One of the goals of chronic pain management is to increase our patients' ability to participate in activities of everyday life. Periodically, we will ask you to fill out questionnaires to help us assess your condition in this regard. Please fill out the following information as follows: (Circle only ONE answer per section)

Pain Intensity:
1. I have no pain at the moment
2. The pain is very mild at the moment
3. The pain is moderate at the moment
4. The pain is fairly severe at the moment
5. The pain is very severe at the moment

Personal Care:
1. I can look after myself normally without causing extra pain
2. I can look after myself normally but it is very painful
3. It is painful to look after myself and I am slow and careful
4. I need some help but manage most of my personal care
5. I need some help every day in most aspects of my self care

Lifting:
1. I can lift heavy weights without extra pain
2. I can lift heavy weights but it gives extra pain
3. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on the table
4. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
5. I can only lift very light weights
6. I cannot lift anything at all

Walking:
1. Pain does not prevent me from walking any distance
2. Pain prevents me from walking more than one mile
3. Pain prevents me from walking more than ½ mile
4. Pain prevents me from walking more than 100 yards
5. I can only walk using a cane or crutches
6. I am in bed most of the time and have to crawl to the toilet

Sitting:
1. I can sit in any chair as long as I like
2. I can sit in my favorite chair as long as I like
3. Pain prevents me from sitting for more than one hour
4. Pain prevents me from sitting for more than ½ hour
5. Pain prevents me from sitting for more than 10 minutes
6. Pain prevents me from sitting at all

Standing:

1. I can stand as long as I want without extra pain
2. I can stand as long as I want but it gives me extra pain
3. Pain prevents me from standing for more than 1 hour
4. Pain prevents me from standing for more than ½ hour
5. Pain prevents me from standing for more than 10 minutes
6. Pain prevents me from standing at all

Sleeping:

1. My sleep is never disturbed by pain
2. My sleep is occasionally disturbed by pain
3. Because of pain I have less than 6 hours of sleep
4. Because of pain I have less than 4 hours of sleep
5. Because of pain I have less than 2 hours of sleep
6. Pain prevents me from sleeping at all

Sex Life:

1. My sex life is normal and causes no extra pain
2. My sex life is normal but causes some extra pain
3. My sex life is normal but is very painful
4. My sex life is severely restricted by pain
5. My sex life is nearly absent because of pain
6. Pain prevents any sex life at all

Social Life:

1. My social life is normal and causes me no extra pain
2. My social life is normal but increases my degree of pain
3. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc.
4. Pain has restricted my social life and I do not go out as often
5. Pain has restricted my social life to home
6. I have no social life because of pain

Traveling:

1. I can travel anywhere without pain
2. I can travel anywhere but it gives extra pain
3. Pain is bad but I can manage journeys over 2 hours
4. Pain restricts me to journeys of less than one hour
5. Pain restricts me to journeys of less than ½ hour
6. Pain prevents me from traveling except to receive treatment