

Please complete the attached questionnaire before your appointment. It is confidential and will be part of your medical record. It asks for information about your current problems and your past medical history. This form will give your doctor a better understanding of your problem, and will allow him or her to spend more time discussing treatment plans with you.

### INITIAL VISIT PATIENT INFORMATION

When you come for your first visit, **please bring this completed form** along with **any medical records, X-rays, CT or MRI scans, medication bottles** and other medical information related to your chronic pain problem. Should you have any questions, please do not hesitate to contact us.

Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Date of Birth \_\_\_\_\_

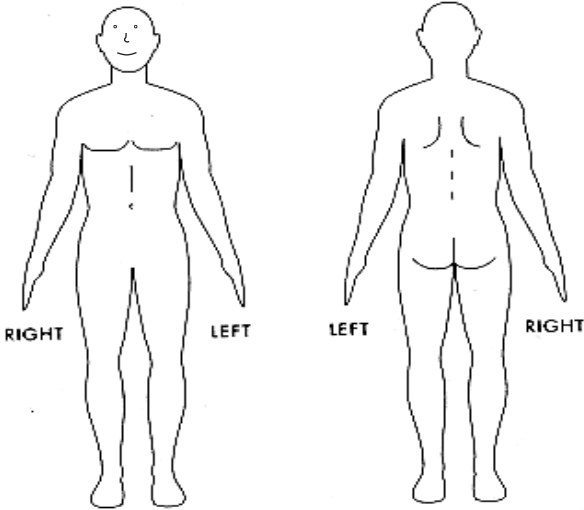
**Primary Care Physician:**

Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
 Address: \_\_\_\_\_

**Front**

**Back**

**What are your activity goals for your pain treatment?**



- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

**How long have you had chronic pain?** month/year \_\_\_\_\_

**Please describe events surrounding the onset of your pain. (i.e., date of injury, activities that made it worse?)**

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**Please shade in the areas where you feel pain. Put an X on the area that hurts the most.**

**In the last year, how many emergency room visits have you had for pain?** (circle) 0    1    2    3    5 – 10

**WHICH WORDS DESCRIBE the QUALITY of your pain:**

- |                            |                   |              |
|----------------------------|-------------------|--------------|
| 1. Throbbing               | 5. Cold freezing  | 8. Shooting  |
| 2. Cramping                | 6. Hot-burning    | 9. Stabbing  |
| 3. Heavy/pressure          | 7. Electric-shock | 10. Itching  |
| 4. Tingling/pins & needles |                   | 11. Numbness |

**Please circle all ACTIVITIES that MAKE YOUR PAIN WORSE:** rest touch sitting standing bending

lifting walking light exercise sex warm compresses cold compresses relaxation techniques Other: \_\_\_\_\_

**Please circle all ACTIVITIES that MAKE YOUR PAIN BETTER:** rest touch sitting standing bending

lifting walking light exercise sex warm compresses cold compresses relaxation techniques Other: \_\_\_\_\_

**Please circle: RELIEF (%) YOU HAVE HAD IN THE LAST 24 HOURS from medications & treatments:**

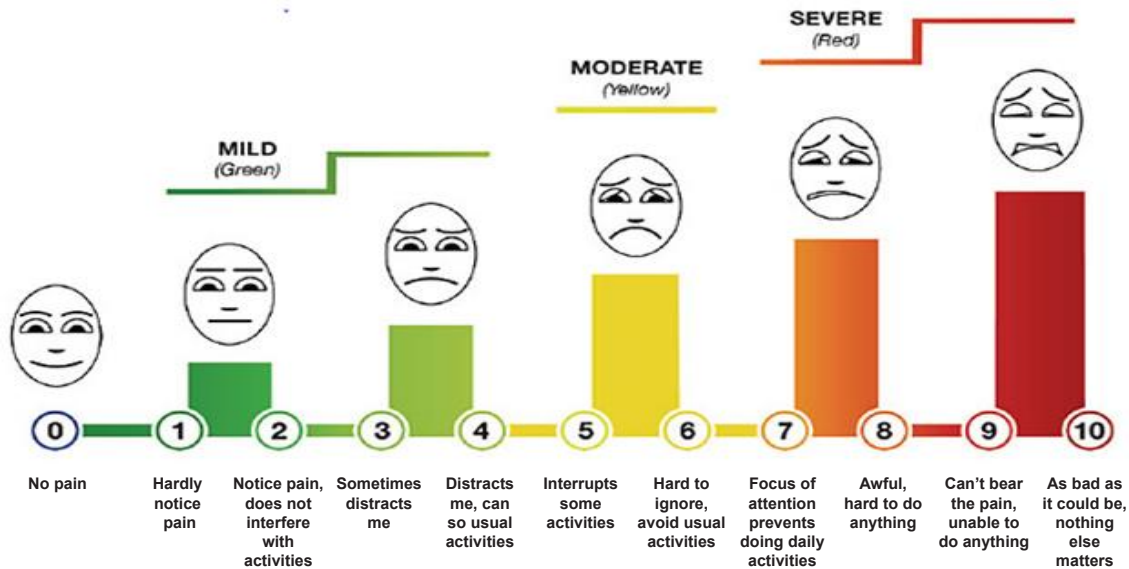
No Relief 0%    10%    20%    30%    40%    50%    60%    70%    80%    90%    100% Complete Relief

**WHEN YOU TAKE YOUR MEDICATION, how many HOURS OF RELIEF do you get?**

\_\_\_\_\_ hours    No help at all.    I do not take pain medications

**Does your pain affect your sleep?**    YES    NO  
**Does your pain cause anxiety?**    YES    NO

**Does your pain cause depression?**    YES    NO



Please circle the number that indicates your **WORST PAIN LEVEL** over the last week:

No pain 0    1    2    3    4    5    6    7    8    9    10    **WORST** you can imagine

Please circle the number that indicates your **LEAST PAIN LEVEL** over the last week:

No pain 0    1    2    3    4    5    6    7    8    9    10    **WORST** you can imagine

Please circle the number that indicates your **AVERAGE PAIN LEVEL** over the last week:

No pain 0    1    2    3    4    5    6    7    8    9    10    **WORST** you can imagine

Please circle the number that indicates your **CURRENT PAIN LEVEL** – RIGHT NOW:

No pain 0    1    2    3    4    5    6    7    8    9    10    **WORST** you can imagine

Please help us understand **HOW PAIN HAS INTERFERED WITH** your:

**A. General Activity**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    **completely interferes**

**B. Mood**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    **completely interferes**

**C. Walking Ability**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    **completely interferes**

**D. Ability to perform tasks at home or at work:**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    **completely interferes**

**E. Relations with other people**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    **completely interferes**

**F. Sleep**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    **completely interferes**

**G. Enjoyment of life**

Does not interfere 0    1    2    3    4    5    6    7    8    9    10    **completely interferes**

**Other Symptoms: PLEASE CIRCLE those you've had DURING THE PAST MONTH:**

<b>General:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> fever</li> <li><input type="checkbox"/> chills</li> <li><input type="checkbox"/> weight loss</li> <li><input type="checkbox"/> weight gain</li> <li><input type="checkbox"/> fatigue</li> <li><input type="checkbox"/> weakness</li> <li><input type="checkbox"/> sweating</li> </ul>	<b>Eyes:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> blurred vision</li> <li><input type="checkbox"/> double vision</li> <li><input type="checkbox"/> sensitivity to light</li> <li><input type="checkbox"/> eye pain</li> <li><input type="checkbox"/> eye drainage</li> <li><input type="checkbox"/> eye redness</li> </ul>	<b>Gastrointestinal:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> heartburn</li> <li><input type="checkbox"/> nausea</li> <li><input type="checkbox"/> vomiting</li> <li><input type="checkbox"/> abdominal pain</li> <li><input type="checkbox"/> diarrhea</li> <li><input type="checkbox"/> constipation</li> <li><input type="checkbox"/> blood in stool</li> <li><input type="checkbox"/> black stool</li> </ul>	<b>Bleeding / Allergic:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> bruise easily</li> <li><input type="checkbox"/> bleeding easily</li> <li><input type="checkbox"/> environmental allergies</li> <li><input type="checkbox"/> increased thirst</li> </ul>
<b>Skin:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> rash</li> <li><input type="checkbox"/> itching</li> </ul>	<b>Cardiovascular:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> chest pain</li> <li><input type="checkbox"/> rapid heartbeat</li> <li><input type="checkbox"/> irregular heartbeat</li> <li><input type="checkbox"/> lying down → short of breath</li> <li><input type="checkbox"/> leg swelling</li> </ul>	<b>Urinary:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> pain</li> <li><input type="checkbox"/> urgency</li> <li><input type="checkbox"/> frequency</li> <li><input type="checkbox"/> urinary incontinence</li> <li><input type="checkbox"/> blood in urine</li> <li><input type="checkbox"/> flank pain</li> <li><input type="checkbox"/> pelvic pain</li> </ul>	<b>Neurologic:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> dizziness</li> <li><input type="checkbox"/> tremor</li> <li><input type="checkbox"/> change in sensation</li> <li><input type="checkbox"/> change in speech</li> <li><input type="checkbox"/> focal weakness</li> <li><input type="checkbox"/> changes alertness</li> </ul>
<b>Head, Ears, Nose, Throat:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> headache</li> <li><input type="checkbox"/> hearing change</li> <li><input type="checkbox"/> ears ringing</li> <li><input type="checkbox"/> ear pain</li> <li><input type="checkbox"/> ear drainage</li> <li><input type="checkbox"/> nosebleeds</li> <li><input type="checkbox"/> congestion</li> </ul>	<b>Respiratory:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> cough</li> <li><input type="checkbox"/> productive cough</li> <li><input type="checkbox"/> coughing blood</li> <li><input type="checkbox"/> short of breath w/ exertion</li> <li><input type="checkbox"/> wheezing</li> </ul>	<b>Musculoskeletal:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> muscle aches</li> <li><input type="checkbox"/> low back pain</li> <li><input type="checkbox"/> neck pain</li> <li><input type="checkbox"/> joint pain</li> <li><input type="checkbox"/> falls</li> </ul>	<b>Psych:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> depression</li> <li><input type="checkbox"/> suicidal thoughts</li> <li><input type="checkbox"/> hallucinations</li> <li><input type="checkbox"/> nervous / anxious</li> <li><input type="checkbox"/> irritability</li> <li><input type="checkbox"/> insomnia</li> <li><input type="checkbox"/> memory problems</li> </ul>

**Have you ever had (currently or in the past):**

- YES NO treatment for **mood, anxiety, and/or sleep disorders?**  
 YES NO **nightmares or flashbacks from prior traumatic experiences?**  
 YES NO **alcohol, illicit drug, or prescription medication misuse/addiction?**  
 YES NO **problems with compulsive behaviors such as gambling, eating disorder, etc.?**  
 YES NO **hospitalization for anxiety or depression?**

If yes, please explain: \_\_\_\_\_

**Pain Management Procedures That You've Had**

	How many	Date(s) performed (Approximate)
___ Trigger Point Injections	_____	_____
___ Medial Branch Nerve Blocks	_____	_____
___ Radiofrequency Nerve Ablation or Rhizotomy	_____	_____
___ Epidural Steroid Injection	_____	_____
___ Caudal Steroid Injection	_____	_____
___ Spinal Cord Stimulator	_____	_____
___ Facet Joint Injection	_____	_____
___ Sacroiliac Joint injection	_____	_____
___ Stellate Ganglion Block	_____	_____
___ Lumbar Sympathetic Block	_____	_____
___ Intercostal Nerve Block	_____	_____
___ Knee Genicular Nerve Block	_____	_____
___ Occipital Nerve Block	_____	_____
___ Botox Injection	_____	_____
___ Kyphoplasty/Vertebroplasty	_____	_____

**How many physicians have been involved in the treatment of your pain? (Please circle)**

0-3                      4-5                      6-10                      11-15                      16-20

**How many emergency room visits have you had in the last year for pain? (Please circle)**

0            1            2            3            5 - 10

**Have you ever been discharged from a pain clinic for any reason? YES NO**

If yes, please explain: \_\_\_\_\_

**Past Medications That You've Tried:** please indicate **Dosage, Benefits & Side Effects:**

<u>Medication</u>	<u>Dose and Frequency</u>	<u>Benefits?</u> <u>Side effects?</u>
<b>Anti-Inflammatory (NSAID's)</b>		
Ibuprofen (Motrin, Advil)	_____	_____
Naproxen (Aleve, Naprosyn, Anaprox)	_____	_____
Meloxicam (Mobic)	_____	_____
Celecoxib (Celebrex)	_____	_____
Toradol (Ketorolac)	_____	_____
<b>Narcotic Pain Medications</b>		
Propoxyphene (Darvocet)	_____	_____
Ultram (Tramadol)	_____	_____
Codeine (Tylenol #3)	_____	_____
Meperidine (Demerol)	_____	_____
Hydromorphone (Dilaudid)	_____	_____
Fentanyl (Duragesic) Patch	_____	_____
Morphine (MS Contin, Kadian, Avinza)	_____	_____
Hydrocodone (Lorcet, Lortab, Vicodin)	_____	_____
Methadone (Dolophine)	_____	_____
Oxycodone ER (Oxycontin)	_____	_____
Oxycodone (Percocet, Roxycodone)	_____	_____
Butorphanol (Stadol)	_____	_____
Pentazocine (Talwin)	_____	_____
Buprenorphine (Suboxone, Subutex)	_____	_____
<b>“Membrane Stabilizers”</b>		
Gabapentin (Neurontin)	_____	_____
Pregabalin (Lyrica)	_____	_____
Valproate (Depokote)	_____	_____
Carbamazepine (Tegretol)	_____	_____
Topiramate (Topamax)	_____	_____
Lamotrigine (Lamictal)	_____	_____
<b>“Anti-Depressants”</b>		
Amitriptyline (Elavil)	_____	_____
Imipramine (Tofranil)	_____	_____
Desipramine (Norpramin)	_____	_____
Doxepin (Sinequan)	_____	_____
Nortriptyline (Pamelor)	_____	_____
Milnacipran (Savella)	_____	_____
Duloxetine (Cymbalta)	_____	_____
Venlafaxine (Effexor)	_____	_____
Desvenlafaxine (Pristiq)	_____	_____
Prozac (Fluoxetine)	_____	_____
Paroxetine (Paxil)	_____	_____
Trazodone (Desyrel)	_____	_____
Bupropion (Wellbutrin)	_____	_____
<b>“Local” or “Topical” (applied to skin)</b>		
Diclofenac (Voltaren) Gel	_____	_____
Lidoderm Patch	_____	_____
Flector Patch	_____	_____
Capsacian	_____	_____
Salonpas, Icy Hot, Bengay, or Tiger Balm	_____	_____

**Past Medications That You've Tried:** please indicate **Dosage, Benefits & Side Effects:**

**Benzodiazepines ("Minor Tranquilizers")**

Diazepam (Valium)	_____	_____
Clonazepam (Klonopin)	_____	_____
Alprazolam (Xanax)	_____	_____
Lorazepam (Ativan)	_____	_____

**Muscle Relaxants**

Baclofen (Lioresal)	_____	_____
Carisoprodol (Soma)	_____	_____
Cyclobenzaprine (Flexeril)	_____	_____
Methocarbamol (Robaxin)	_____	_____
Metazalone (Skelaxin)	_____	_____
Tizanidine (Zanaflex)	_____	_____

**Past Medical History**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Surgical History**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:**

\_\_\_\_\_

Are you allergic to **Iodine** or **IV contrast dye**? YES NO

**FAMILY HISTORY:**

Please list family members' illnesses (cancer, diabetes, psych, substance use, etc.) \_\_\_\_\_

YES NO Any family members have / had **alcohol, illicit drug, or prescription med misuse/addiction?**

YES NO Problems with **compulsive behaviors** such as **gambling, eating disorder, etc.?**

YES NO Does **anyone in your household take prescription pain medications?**

YES NO Does **anyone in your household use illicit drugs?**

**SOCIAL HISTORY**

**Marital status:**      Single                  Married                  Separated                  Divorced                  Widowed

**Who lives at home with you?** \_\_\_\_\_

Family support:    STRONG                  AVERAGE                  MINIMAL                  NONE

Your **sources of enjoyment &/or support** (family, friends, hobbies)? \_\_\_\_\_

What are your **sources of stress** (family, finances, etc.)? \_\_\_\_\_

**Employment:**

YES NO **Are you currently employed?**    Occupation \_\_\_\_\_ #Hrs/day \_\_\_\_\_ # Days/week \_\_\_\_\_

**IF NO: When did you last work?** \_\_\_\_\_ **What was your most recent job?** \_\_\_\_\_

YES NO **Are you currently receiving disability benefits?** Since when? \_\_\_\_\_

YES NO **Are you involved with Worker's Compensation?**    YES NO    Is there **litigation pending?**    YES NO

**Spirituality and/or Religion: an important role in your life?** \_\_\_\_\_

**Education:** please circle the highest level of education you have completed

- Grade School    High School    Junior College    Trade School  
Some College    Graduated College    Graduate / Professional School

**SUBSTANCE USE**

YES NO **Do you smoke cigarettes?**    How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

**If you are a former smoker when did you quit?** \_\_\_\_\_ How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

YES NO **Do you use alcohol?** About how often? \_\_\_\_\_ For how many years? \_\_\_\_\_

YES NO **Do you use illegal drugs?** About how often? \_\_\_\_\_ For how many years? \_\_\_\_\_

YES NO **Have you ever had a problem w/ alcohol, illicit drugs, or prescription meds?** If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HAVE YOU EVER:**

YES NO **had prescription pain medications lost or stolen?**

YES NO **shared your prescription pain medications with others** (family, friends)?

YES NO **taken more prescription pain medication than prescribed, or run out early?**

YES NO **taken prescription pain medications to relieve non-pain symptoms** (anxiety, sleep)?

YES NO **consumed prescription pain meds that were not prescribed to you** (from family, friend)?

YES NO **altered a prescription pain pill for enhanced effect** (such as crushing a time-release tab)?

YES NO **been in a treatment program for alcohol or drug abuse?**

YES NO **attended a 12 step meeting such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?**

YES NO **had a DUI or been arrested for using or selling illicit drugs?**

YES NO **had a drug overdose?**

YES NO **Had someone express concern about your overuse of prescription pain meds, drugs or alcohol?**

YES NO **been discharged from a pain clinic for any reason?** If yes, please explain:

\_\_\_\_\_  
**IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name of last physician or clinic where you received treatment for chronic pain: \_\_\_\_\_

Why are you no longer being treated there? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**THANK YOU FOR COMPLETING THIS FORM.**

**WE LOOK FORWARD TO THE OPPORTUNITY TO PARTICIPATE IN YOUR CARE.**