

Pain Management & Treatment Center, S.C.

A medical practice dedicated to the treatment of pain.



Pain Management & Treatment Center, S.C.

Signature of Physician

Date: _____

Date of Birth: _____

Name: _____

(First)

(MI)

(Last)

Referred By: _____

For what problem / treatment? _____

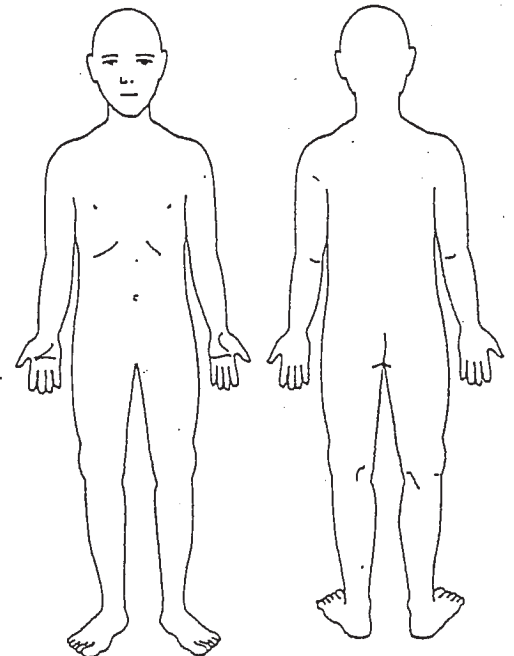
Family Doctor: _____

PAIN DESCRIPTION

Please indicate on the diagram where your pain occurs by shading the painful area(s):

WHAT IS THE LOCATION OF YOUR PAIN? (Check all areas that apply)

- | | |
|---|--|
| <input type="checkbox"/> Entire Body | <input type="checkbox"/> Right Buttock |
| <input type="checkbox"/> Head | <input type="checkbox"/> Both Buttocks |
| <input type="checkbox"/> Face | <input type="checkbox"/> Left Hip |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Right Hip |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Both Hips |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Left Thigh |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Right Thigh |
| <input type="checkbox"/> Right Upper Quadrant-Abdomen | <input type="checkbox"/> Both Thighs |
| <input type="checkbox"/> Right Lower Quadrant-Abdomen | <input type="checkbox"/> Right Knee |
| <input type="checkbox"/> Left Upper Quadrant-Abdomen | <input type="checkbox"/> Left Knee |
| <input type="checkbox"/> Left Lower Quadrant-Abdomen | <input type="checkbox"/> Both Knees |
| <input type="checkbox"/> Left Groin | <input type="checkbox"/> Left Calf |
| <input type="checkbox"/> Right Groin | <input type="checkbox"/> Right Calf |
| <input type="checkbox"/> Left Shoulder | <input type="checkbox"/> Both Calves |
| <input type="checkbox"/> Right Shoulder | <input type="checkbox"/> Left Ankle/Foot |
| <input type="checkbox"/> Both Shoulders | <input type="checkbox"/> Right Ankle/Foot |
| <input type="checkbox"/> Left Arm | <input type="checkbox"/> Bilateral Ankles/Feet |
| <input type="checkbox"/> Right Arm | |
| <input type="checkbox"/> Both Arms | |
| <input type="checkbox"/> Left Hand/Wrist | |
| <input type="checkbox"/> Right Hand/Wrist | |
| <input type="checkbox"/> Both Hands/Wrists | |
| <input type="checkbox"/> Upper Back | |
| <input type="checkbox"/> Middle Back | |
| <input type="checkbox"/> Lower Back | |
| <input type="checkbox"/> Left Buttock | |



When did you first notice your pain? Month: _____ Day: _____ Year: _____
 if accident, please describe: _____

Describe your pain:

- aching
- burning
- constant
- cramping
- dull
- gnawing
- heavy
- improving
- intermittent
- sharp
- shooting
- soreness
- splitting
- stabbing
- stable
- stiff
- tender
- throbbing
- worsening

Pain is made worse by:

- bending backward
- bending forward
- bending to same side
- bending to opposite side
- coughing/sneezing
- damp weather
- driving
- exercising
- going up or down stairs
- heat
- housework
- lifting
- lying down
- medications
- nerve block injections
- overhead activity
- physical therapy
- resting
- sexual activity
- sitting
- standing
- stress
- walking
- yard work

Pain is made better by:

- doing nothing
- bending backward
- bending forward
- bending to same side
- bending to opposite side
- coughing/sneezing
- Biofreeze gel
- damp weather
- driving
- exercising
- going up or down stairs
- heat
- housework
- ice
- lifting
- lying down
- medications
- massage
- nerve block injections
- physical therapy
- physical activity
- resting
- sexual activity
- sitting
- standing
- TENS unit

Pain Radiates to:

- head
- face
- headache
- neck
- chest
- abdomen
- right upper quadrant-abdomen
- right lower quadrant-abdomen
- left upper quadrant-abdomen
- left lower quadrant-abdomen
- left groin
- right groin
- left shoulder
- right shoulder
- both shoulders
- left arm
- right arm

- both arms
- left upper extremity
- right upper extremity
- both upper extremities
- left hand/wrist
- right hand/wrist
- both hands/wrists
- upper back
- middle back
- lower back
- left buttock
- right buttock
- both buttocks
- left hip
- right hip
- both hips
- left thigh

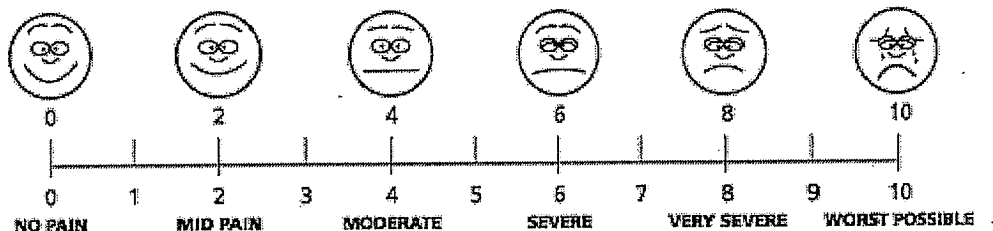
- right thigh
- both thighs
- right knee
- left knee
- both knees
- left calf
- right calf
- both calves
- left lower extremity
- right lower extremity
- both lower extremities
- left ankle/foot
- right ankle/foot
- both ankles/feet

My symptoms include:

- | | | |
|---|--|---|
| <input type="checkbox"/> numbness | <input type="checkbox"/> swelling | <input type="checkbox"/> problems with bladder |
| <input type="checkbox"/> tingling | <input type="checkbox"/> increased hair growth | <input type="checkbox"/> muscle spasms in neck |
| <input type="checkbox"/> pins and needles | <input type="checkbox"/> decreased hair growth | <input type="checkbox"/> muscle spasms lower back |
| <input type="checkbox"/> weakness | <input type="checkbox"/> shiny thin skin | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> coldness | <input type="checkbox"/> problem with bowel | <input type="checkbox"/> difficulty sleeping |
-

SEVERITY OF PAIN

Please use the following rating scales to indicate the severity of your Pain



Your pain at it's worst:

- 0 1 2 3 4 5 6 7 8 9 10

Your pain at it's least severe:

- 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

Which statement describes your pain?

- always present and always has the same intensity
- always present and 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 once to several times a day lasting a few minutes to one hour
- rarely present but have pain every few days or weeks

What time of day is your pain the worst?

- 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? Yes No

If yes, please list: _____ Date: _____

Approximately how many emergency room visits have you had for your pain in the past year?

None 1 to 5 6 to 10 10-20 20-30 No ER visits.

How are you coping with your pain?

depressed frustrated angry hopeless other (please describe)

PREVIOUS TREATMENTS

Have you been to another pain clinic? Yes No If yes, where?

I have had these treatments and they **DID help**

aquatic therapy
 biofeedback
 TENS Unit
 acupuncture
 chiropractor
 myofascial release
 traction
 psychotherapy
 psychiatric
 occupational therapy
 physical therapy
 cranial sacral therapy
 trigger point therapy

I have had these treatments and they **DID NOT help**

aquatic therapy
 biofeedback
 TENS Unit
 acupuncture
 chiropractor
 myofascial release
 traction
 psychotherapy
 psychiatric
 occupational therapy
 physical therapy
 cranial sacral therapy
 trigger point therapy

I have **NOT** had these:

aquatic therapy
 biofeedback
 TENS Unit
 acupuncture
 chiropractor
 myofascial release
 traction
 psychotherapy
 psychiatric
 occupational therapy
 physical therapy
 cranial sacral therapy
 trigger point therapy

Other: _____ Did it help? Yes No

CIRCLE PREVIOUS MEDICATIONS:

OPIOID examples include: Vicodin, Darvocet, Codeine, Tylenol #3, Percocet, Methadone, Oxycontin, Kadian, MS Contin, Avinza, Duragesic Patch, Morphine Sulfate, Dilaudid, Actiq

Anti-Depressant examples include: Paxil, Prozac, Effexor, Lexapro, Cymbalta, Amitriptyline, Remeron, Doxipin, Serzone

NSAID examples include: Celebrex, Vioxx, Ibuprofen, Bextra, Mobic, Naprosyn

Anti-Convulsant examples include: Neurontin, Gabitril, Keppra, Zonegran, Topomax, Lamictal

Muscle Relaxer examples include: Robaxin, Skelaxin, Zanaflex, Flexeril, Soma, Norflex

I HAVE TRIED:	They DID help	They DID NOT help
Opiods	[]	[]
Anti-Depressants	[]	[]
NSAIDS	[]	[]
Anti-Convulsants	[]	[]
Muscle Relaxers	[]	[]

PREVIOUS INJECTIONS

Type	Number done	Did Help	Did NOT help
<input type="checkbox"/> Epidural Steroid Injection Circle type: cervical thoracic lumbar _____		[]	[]
<input type="checkbox"/> Facet Injection Circle type: cervical thoracic lumbar _____		[]	[]
<input type="checkbox"/> SI Joint injection Circle side: Left Right Both _____		[]	[]
<input type="checkbox"/> Radiofrequency Nerve Ablation Which nerves? _____		[]	[]
<input type="checkbox"/> Other: _____		[]	[]

ACTIVITIES

Does pain prevent you from taking part in social activities? [] Yes [] No

Does pain prevent you from taking part in recreational activities? [] Yes [] No

How many hours do you sleep per 24-hour day? _____

How many hours per 24-hour day did you sleep before your pain began? _____

PLEASE COMPLETE THE ENTIRE LIST
OR
BRING IN YOUR MEDICATION BOTTLES
IN ORDER TO FACILITATE CARE AT YOUR FIRST VISIT.

PRESCRIPTION MEDICATIONS you are currently taking

Name of medication

Strength

Times per day

Name of medication	Strength	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Non-Prescription (Over-the-Counter) Medications you are currently taking
(please include herbal supplements and vitamins for accuracy)

Name of medication

Strength

Times per day

Name of medication	Strength	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Food Allergies:

_____	_____	_____
_____	_____	_____

Environmental Allergies:

_____	_____	_____
_____	_____	_____