

PATIENT NAME

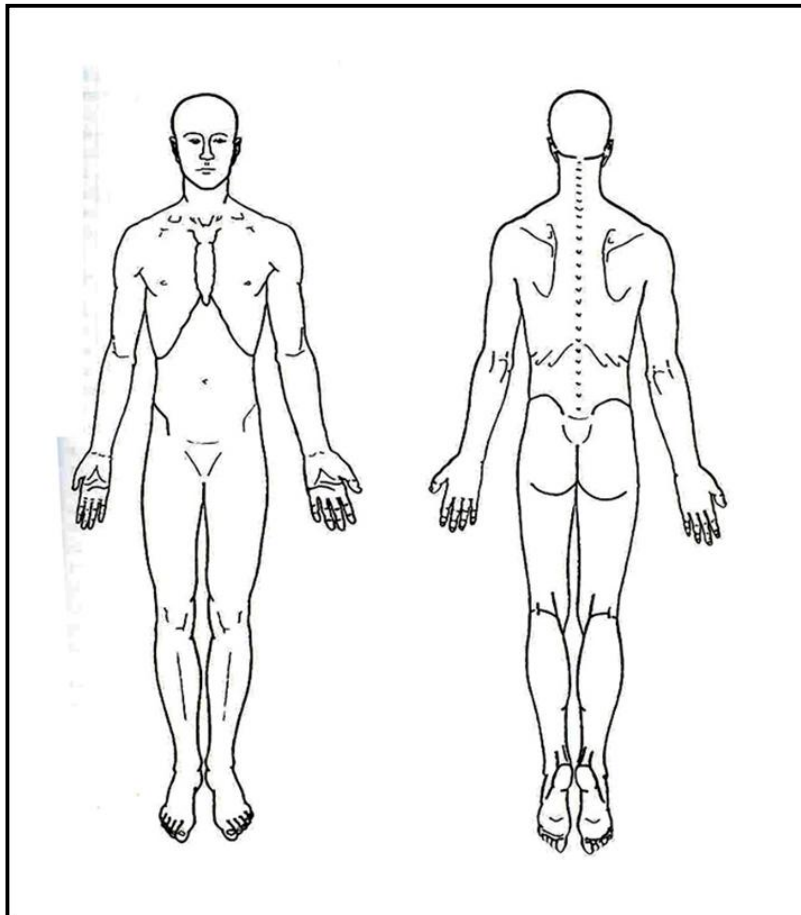
DATE OF BIRTH

REFERRING PHYSICIAN

**IMPORTANT!! INSTRUCTIONS TO PATIENT:**

Bring any relevant medical records, Xray and MRI or CT scan reports & images if you have them, a copy of your **current medication list with dosages and frequency**, as well as all of your **current medication bottles**, etc. Completing this pain inventory and following these suggestions will make your first visit with us smooth and productive.

Please color your areas of pain on the diagrams below. Be sure to show pain going down the arms or legs.



**TELL US ABOUT YOUR MOST SIGNIFICANT AND DISTRESSING PAIN PROBLEM**

**WHERE is your MOST SIGNIFICANT AND DISTRESSING pain?**

<p><b>Was there an ACCIDENT OR INJURY? Give the DATE, and please describe</b></p>
<p><b>WHEN did THIS PARTICULAR pain start?</b></p>
<p><b>Are you followed by a WORKER'S COMPENSATION CASE MANAGER?</b></p>
<p><b>What is your average pain score, where 0=NO pain, and 10=MOST SEVERE pain imaginable:</b></p> <p style="text-align: center;">0    1    2    3    4    5    6    7    8    9    10</p>
<p><b>How do you describe the QUALITY of your pain?</b></p> <p style="text-align: center;">sharp shooting aching throbbing deep electrical spastic/tight piercing burning</p>
<p><b>Does your pain radiate (travel) anywhere? (Where?)</b></p>
<p><b>Is this pain CONSTANT or INTERMITTENT?</b></p>
<p><b>What activities or positions INCREASE this pain?</b></p> <p style="text-align: center;">walking, standing, sitting, exercise, work activities, motion of the head, <u>other:</u></p>
<p><b>What activities or positions DECREASE this pain?</b></p> <p style="text-align: center;">rest, heat, ice, physical therapy, TENS, chiropractic, injections, medications, <u>other:</u></p>
<p><b>Do you experience NEW problems with your BOWEL MOVEMENT or BLADDER FUNCTION?</b></p>
<p><b>Do you have NUMBNESS OR WEAKNESS anywhere?</b></p>
<p><b>Have you had NECK (Cervical spine) or BACK (Lumbar spine, Thoracic spine) SURGERY? Please provide Surgeon, Dates and Type of operation:</b></p>
<p><b>What THERAPIES or INTERVENTIONS have you had for YOUR CURRENT PAIN problem? (circle)</b></p> <p style="text-align: center;">physical therapy, spine injections, chiropractor, anti-inflammatory medications, pain medications, bedrest, TENS unit, a previous pain management physician, or NONE</p>

<p><b>Have you had any XRAYs or OTHER STUDIES done for YOUR CURRENT PAIN PROBLEM? (circle)</b></p> <p style="text-align: center;">XRAYs, MRI, CAT Scan, EMG (needle testing of muscles), Nerve conduction study, Discogram, Myelogram, <u>Others:</u></p>	
<p><b>MEDICAL, SURGICAL , FAMILY, MEDICATION AND SOCIAL HISTORY</b></p>	
<p><b><u>PAST MEDICAL HISTORY:</u></b> Please DESCRIBE your medical problems or LIST DIAGNOSES:</p>	
<p><b><u>PAST SURGICAL HISTORY:</u></b> Please LIST your major surgical procedures &amp; dates</p>	
<p><b><u>FAMILY HISTORY:</u></b> LIST SERIOUS problems your PARENTS, GRANDPARENTS or CHILDREN experienced</p>	
<b><u>DRUG ALLERGIES:</u></b>	<u>What happens if you take this drug (reaction)?</u>
<p><b><u>ARE YOU ALLERGIC To:</u></b> IODINE, BETADINE, CONTRAST DYE, OR LATEX or <b><u>NONE</u></b></p>	
<b><u>MEDICATIONS THAT THIN YOUR BLOOD:</u></b> Do you take any of the following OR SIMILAR?	coumadin, plavix, aspirin 325, Goody's powders, aggrenox, ticlid, pletal, trental, heparin, lovenox or <u>OTHER</u> or <b><u>NONE</u></b>
<b>DO YOU SMOKE?</b>	NO, or _____ PACKS, Cigars, Pipes per day / week
<b>DO YOU EVER USE ANY STREET DRUGS?</b>	NO or marijuana, cocaine, other: _____
<b>DO YOU DRINK ALCOHOL?</b>	NO, or _____ drinks per day/ week/ month
<b>DO YOU HAVE A HISTORY OF HEAVY ALCOHOL USE OR ALCOHOLISM?</b>	
<b>DO YOU HAVE A HISTORY OF ANY DRUG ADDICTION?</b> NO or YES	
<b>Do you work outside of the home?</b>	NO or occupation: _____
<p><b>FOR FEMALES OF CHILDBEARING AGE ONLY, many pain medications, X Rays and injections are potentially dangerous to an unborn baby. Is there any chance that you may be pregnant? If NO, why not?</b></p>	