Name:_____ **DOB#:**_____ **Today's Date:**_____

PAIN DESCRIPTION

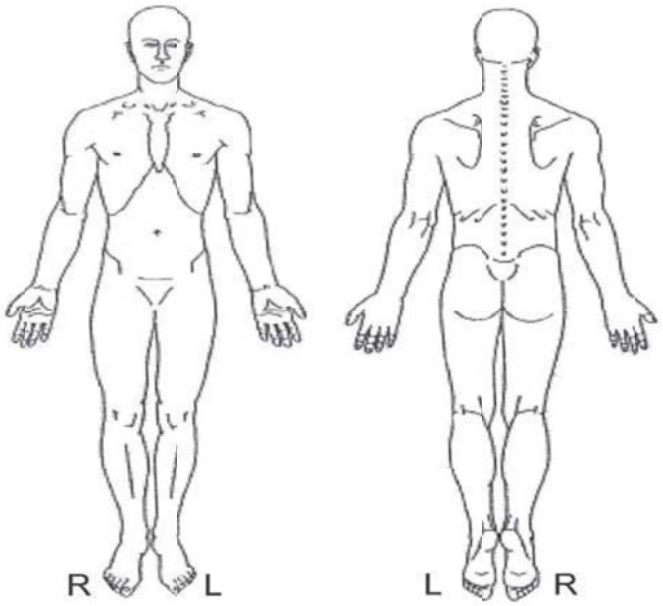
What is the Problem?_____

When did it Start?_____ How did it Start? __Gradually __Suddenly __Other:_____

Was there a specific event? (Car accident, fall, etc)_____

Location

Where do you hurt? (Please shade 1 main area)



Quality

What does your pain feel like?

__Burning __Aching __Sharp
__Electric __Throbbing __Stabbing
__Prickling __Dull __Shooting
__Numbing __Cramping __Stinging
__Other (Describe)_____

Timing

How often do you have pain?

__Constant __Frequent __Occasional __Rare

What time of day/night is your pain the worst?

__Morning __Afternoon __Evening __During sleep

Modifying Factors

What makes your pain BETTER?_____

_____

What makes your pain WORSE?_____

_____

Severity

What is your pain level on AVERAGE?

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

(0= no pain, 10=pain so severe you can't even speak)

What is your pain level at its BEST?

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

What is your pain level at its WORST?

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

Associated Symptoms

Which of the following occur WITH your pain?

__Numbness __Fatigue
__Weakness __Nausea/Vomiting
__Tingling __Sensitivity to Light
__Muscle Spasm __Sensitivity to Sound
__Restlessness __Other_____

Mobility

Do you use any device to help with your mobility?

__Cane __Walker __Wheelchair __Scooter

__All the time __Occasionally __As needed __Rarely

Activity

Is there anything you used to do which you cannot do now because of pain?_____

_____

_____

Name:_____ **DOB#:**_____ **Today's Date:**_____

PREVIOUS PAIN TREATMENT

(Please tell us about ALL previous treatment you have received)

MEDICATIONS

Anti-Inflammatory

	Helpful	Not Helpful
Ibuprofen (*Advil*)	___	___
Naproxen (*Aleve/Naprosyn*)	___	___
Celecoxib (*Celebrex*)	___	___
Diclofenac (*Voltaren*)	___	___
Meloxicam (*Mobic*)	___	___
Etodolac (*Lodine)*	___	___
Other:_____	___	___

Neuropathic/Antidepressants

	Helpful	Not Helpful
Amitriptyline (*Elavil*)	___	___
Gabapentin (*Neurontin)*	___	___
Pregabalin (*Lyrica)*	___	___
Topiramate (*Topamax)*	___	___
Duloxetine (*Cymbalta)*	___	___
Milnacipran (*Savella)*	___	___
Nortriptyline (Pamelor)	___	___
Other _____	___	___

Muscle Relaxants

	Helpful	Not Helpful
Baclofen	___	___
Cyclobenzaprine (*Flexeril)*	___	___
Tizanidine (*Zanaflex)*	___	___
Metalaxone (*Skelaxin)*	___	___
Methocarbamol (*Robaxin)*	___	___
Orphenadrine (*Norflex*)	___	___
Other: _____	___	___

Other Medications

	Helpful	Not Helpful
Acetaminophen (*Tylenol)*	___	___
Lidoderm Patch	___	___
Flector Patch	___	___
Voltaren Gel	___	___
Pennsaid	___	___
Other:_____	___	___

Opioid – Short Acting

	Helpful	Not Helpful
Tramadol (*Ultram)*	___	___
Hydrocodone (*Vicodin/Norco)*	___	___
Morphine (*MS IR)*	___	___
Oxycodone (*Percocet/Tylox)*	___	___
OxyMorphone (*Opana)*	___	___
Tapentadol (*Nucynta)*	___	___
Dilaudid	___	___
Darvocet	___	___
Other _____	___	___

Opioids – Long Acting

	Helpful	Not Helpful
Morphine ER (*MS Contin)*	___	___
OxyCodone ER (*OxyContin)*	___	___
OxyMorphone ER (*Opana ER)*	___	___
Fentanyl Patch (*Duragesic)*	___	___
Methadone	___	___
Dilaudid (*Exalgo)*	___	___
Butrans Patch	___	___
Hydrocodone ER (Zohydro, Hysingla)	___	___
Other_____	___	___

INTERVENTIONS/INJECTIONS

	Helpful	Not Helpful
Epidural Steroid	___	___
Facet Injection/Ablation	___	___
Other pain injections	___	___
Spinal Cord Stimulation	___	___
Surgery:_____	___	___
Other:_____	___	___

PHYSICAL THERAPY/TREATMENT

	Helpful	Not Helpful
Physical Therapy	___	___
Water Therapy/ Aerobics	___	___
Massage	___	___
TENS	___	___
Chiropractic	___	___
Acupuncture	___	___
Other:_____	___	___

PSYCHOSOCIAL THERAPY

	Helpful	Not Helpful
Counseling for *depression* or *anxiety* related to pain	___	___
Pain coping skills	___	___
Biofeedback	___	___
Other_____	___	___

Name:_____ **DOB#:**_____ **Today's Date:**_____

PERSONAL MEDICAL HISTORY

CURRENT MEDICATIONS	**MEDICAL HISTORY**
List ALL of your current medications, dosage & frequency: _____ _____ _____ _____ _____ _____ _____ _____	Are you Diabetic? __Y __N Are you on a Blood Thinner? __Y __N (Why?_____) List All other medical conditions for which you are treated: _____ _____ _____ Have you been diagnosed with obstructive sleep apnea? __Y __N Have you even been diagnosed with depression/anxiety/bipolar disorder? ___Y ___N
ALLERGIES	**SURGICAL HISTORY**
Are you allergic to: __Latex? __Iodine? __Shellfish? List all Drug allergies and your *Reaction* _____ _____ _____ _____	List all surgeries (or attach list if needed) Year of Surgery _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
SOCIAL HISTORY	
What is your Marital Status?_____ Do you have Children/Dependents? _____ What is the highest level of Education you achieved? _____ What is your Occupation? _____ Work Status: __Full time __Part time __Not working Are you Disabled? __Y __N Why?_____ How long?_____	Do you Smoke? __Y __N __Quit (when? _____) How many packs/day?_____ How long?_____ Do you drink Alcohol? __Y __N __Quit How many drinks/week?_____ Do you use illicit or street drugs? __Y __N __Quit Drug(s):_____ Have you ever been entered into a drug rehabilitation program? __Y __N
FAMILY HISTORY	
Is there a family history of: __cancer __arthritis __substance abuse __bleeding disorder Describe:_____	What other medical problems run in your family? _____ _____
REVIEW OF SYSTEMS (to be completed by patient)	
Constitutional: __ chills __fever __weight loss *Skin*: __rash __ulcers *Cardiovascular:* __chest pain __high blood pressure *HEENT:* __blurred vision __ringing in ears __vertigo *Resp*: __cough __wheezing __shortness of breath *CV:* __chest pain __palpitations __edema	*GI:* __constipation __diarrhea __heartburn *Neuro:* __fainting __seizures *Psychiatric:* __tiredness __ fogginess __personality changes *Endocrine*:__ sweating __hot flashes __sexual dysfunction *Hematology:* __easy bruising __easy bleeding __nose bleeds

Patient Signature_____ Staff Initials_____