Premier Pain Consultants

Advanced Solutions For Pain Relief

Office Use Only

Blood Pressure: _____

Heart Rate: _____

Temperature: _____

Weight: _____

Name:_____

DOB:_____

Who is your primary care physician/family doctor?

_____

What is the major reason you are coming to see the doctor (chief complaint):

_____

_____

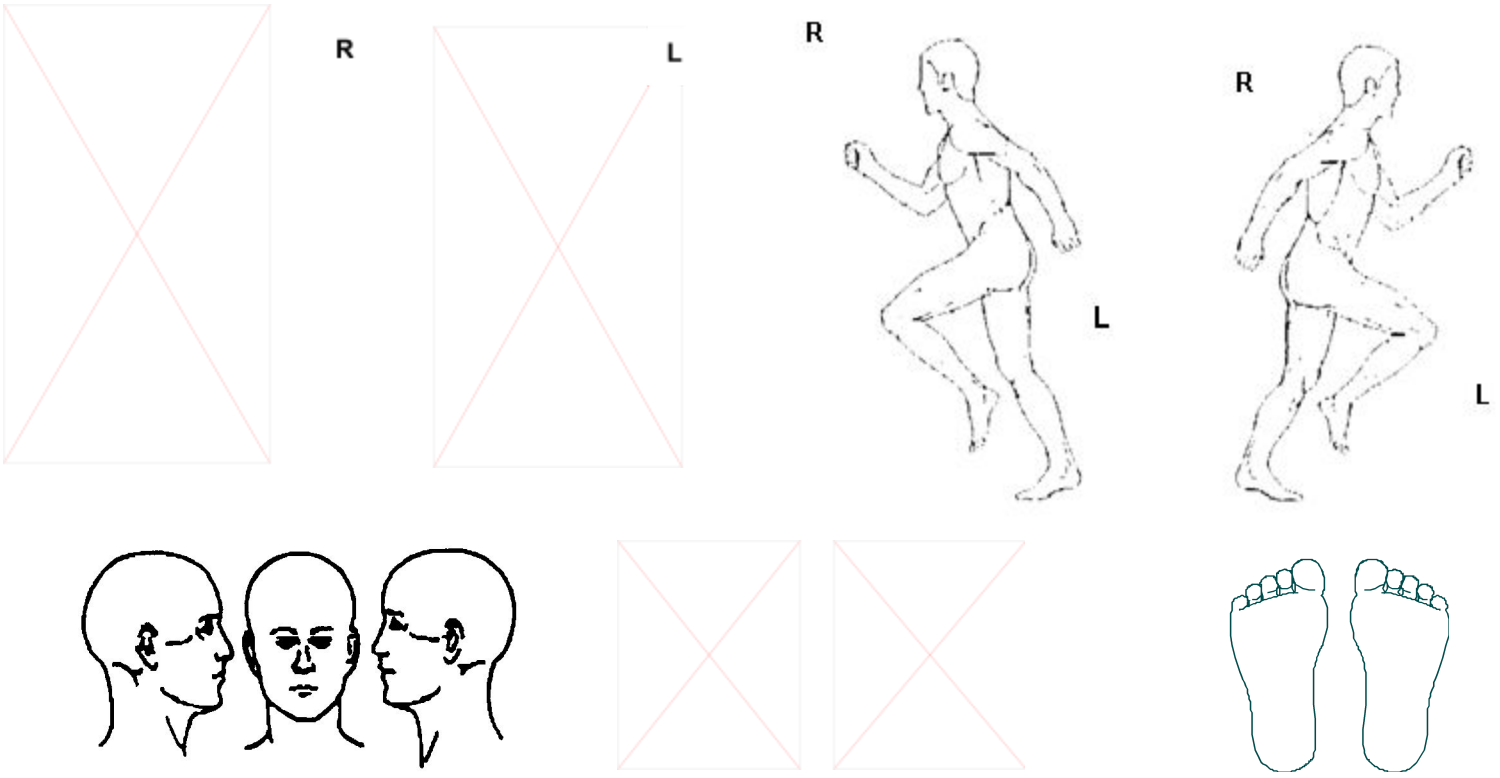
_____

How long have you had this pain? _____

When did it start? _____

What were you doing when the pain first started? _____

Mark an "X" on the figure below where your pain starts and show where it goes with an arrow.



Intensity of Pain

On a scale of 0-10, with 10 being the worst pain and 0 the absence of pain, how would you rate your pain?

At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
Average:	0	1	2	3	4	5	6	7	8	9	10

How long does the pain last?

( ) Constant ( ) Intermittent

Quality of your pain: Mark all that apply

( ) Throbbing ( ) Cramping ( ) Gnawing ( ) Aching ( ) Shooting ( ) Stabbing
( ) Sharp ( ) Hot-burning ( ) Heavy ( ) Tender ( ) Splitting ( ) Sickening
( ) Tiring-Exhausting ( ) Fearful ( ) Punishing-Cruel ( ) Other _____

What makes your pain worse? Mark all that apply.

( ) Bending ( ) Lifting ( ) Coughing ( ) Sneezing ( ) Defecation
( ) Prolonged Sitting ( ) Walking ( ) Prolonged Standing ( ) Other, please explain_____

What makes your pain better? Mark all that apply.

( ) Rest ( ) Activity/physical therapy ( ) Massage ( ) Heat ( ) Cold
( ) Lying in a fetal position ( ) Lying on your back ( ) Lying on back w/ pillows under your legs
( ) Medication, please list _____ ( ) Other, please explain_____

Are there other symptoms/problems associated with the pain?

( ) Difficulty sleeping ( ) Feel "blue" all the time ( ) Other(s), please describe. _____

In what time period is your pain worst?

( ) early morning ( ) late evening

TREATMENT HISTORY

How many times have you visited a professional caregiver (of any kind) for this *current* pain?

( ) 0-5 ( ) 6-10 ( ) Can't Remember ( ) Too many to count

Which of the following types of caregivers have you visited prior to your arrival here?

( ) Family Physician (includes general practitioner, internist, gynecologist, etc.)
( ) Sports Medicine ( ) Orthopedic/Spine Surgeon ( ) Neurologist ( ) Rheumatologist
( ) Occupational Medicine ( ) Rehabilitation Medicine ( ) Anesthesiologist ( ) Chiropractor
( ) Pain Management ( ) Osteopathic Physician ( ) Acupuncturist ( ) Biofeedback
( ) Alternative medicine ( ) Physical Therapist ( ) Other, please list _____

Which of the following tests have you undergone prior to your arrival here today?

( ) X-rays ( ) CAT scan ( ) MRI scan ( ) EMG test ( ) Discogram/Discography ( ) Myelogram

Please check the medications that you have tried for your pain in the past and their effectiveness. (0=no help, 10=very helpful)

Tried Medication			
Name of medication	**Yes**	**No**	**Effectiveness (0-10)**
Tylenol/acetaminophen			
NSAID's: Motrin/Advil/Ibuprofen,etc			
Oral Steroids/Medrol dose pack			
Amitriptyline(Elavil), Nortriptyline(Pamelor), etc			
Muscle relaxants/Flexaril			
Neurontin/Topamax/Tegretol, etc			
Marijuana/Cocaine/Herion/Other illicit drugs			
Xanax/Ativan/Valium,etc			
Opioids: Vicodin/Norco/Oxycodone, etc			
Others, please list			

Have you had any of the following interventions done for your pain?

( ) TENS/nerve stimulator ( ) ultrasound ( ) Heat ( ) Cold

( ) Nerve block injections (not steroids) If so, how many times? • 1 • 2 • 3 • 4 or more
( ) Trigger point injections If so, how many times? • 1 • 2 • 3 • 4 or more
( ) Other, please list _____

PAST MEDICAL HISTORY

Drug and Food Allergies: _____

Please list the medications you are currently taking:

Name	Dosage	How Often?

List all **MEDICAL** problems:

_____
_____
_____

List all **SURGERIES** and their dates:

_____
_____
_____

SOCIAL HISTORY

Any use of tobacco (type, pack(s) per day, and for how long?)_____
Any use of alcohol (type and for how long? _____
Any use of recreational drugs (type and for how long?)_____
Any exposure to toxins/poisonous substances at work or with hobbies? _____
What type of work do you do?_____
Are you currently on disability: **( )Yes** **( )No**
Education:
( ) Grade School **( )**High School **( )**College **( )**Post-Graduate **( )**Vocational Training
Marital Status:
( ) Single **( )**Married **( )**Divorced **( )**Separated **( )**Widowed
Race:
( ) American Indian or Alaska Native **( )**Asian **( )**Black or African American **( )**Hispanic
( ) Native Hawaiian or Other Pacific Islander **( )**White **( )**Other_____

FAMILY HISTORY

Mother: **( )** Living **( )** Deceased Age(s) _____ Health issues: _____

Father: **( )** Living **( )** Deceased Age(s) _____ Health issues: _____

Brother(s): **( )** Living **( )** Deceased Age(s) _____ Health issues: _____

Sister(s): ( ) Living **( )** Deceased Age(s) _____ Health issues: _____

REVIEW OF SYSTEMS

Please place a checkmark if you currently have any of the following symptoms. (Disregard the bold headings)

• Constitutional

( ) No Problems ( ) Fever ( ) Weight Loss ( ) Fatigue

• Eyes

( ) No Problems ( ) Blurred Vision ( ) Eye Redness ( ) Double Vision ( ) Vision Loss

( ) Eye Dryness ( ) Eye Pain

• Ear/Nose/Throat

( ) No Problems ( ) Trouble Hearing ( ) Ringing in the ear ( ) Loss of Balance ( ) Dizziness/Vertigo

( ) Ear Discharge ( ) Ear Pain

• Cardiovascular

( ) No Problems ( ) Chest Pain/Angina ( ) Irregular Heart Beat ( ) Fainting ( ) Limb Swelling

( ) Limb Pain on Walking

• Respiratory

( ) No Problems ( ) Trouble Breathing ( ) Chronic Cough ( ) Coughing Blood

• Gastointestinal

( ) No Problems ( ) Indigestion ( ) Nausea ( ) Vomiting ( ) Diarrhea

( ) Heart Burn ( ) Constipation ( ) Bloody Stools ( ) Abdominal Pain

• Genitourinary

( ) No Problems ( ) Incontinence ( ) Pain on Urination ( ) Blood in Urine

• Musculoskeletal

( ) No Problems ( ) Muscle Pain ( ) Muscle Cramp ( ) Neck Pain ( ) Back Pain

( ) Joint Swelling ( ) Joint Pain ( ) Joint Stiffness ( ) Muscle Twitches

• Skin & Breast

( ) No Problems ( ) Numbness ( ) Hair Loss ( ) Discoloration ( ) Tingling

( ) Sweating Change ( ) Nail Change

• Neurologic

( ) No Problems ( ) Headache ( ) Weakness ( ) Tremors ( ) Seizures

( ) Trouble with Memory/Concentration ( ) Blackouts ( ) Face Numbness/Pain

• Psychiatric

( ) No Problems ( ) Hallucinations ( ) Feeling Down ( ) Trouble Sleeping ( ) Suicidal Thoughts

( ) Inappropriate Crying/Laughing

• Hematologic/Lymphatic

( ) No Problems ( ) Abnormal Bleeding ( ) Anemia ( ) Lumps/Swellings

• Allergic/Immunologic

( ) No Problems ( ) Rash ( ) Joint Pain ( ) Dry Eyes +/- Mouth

• Endocrinologic

( ) No Problems ( ) Excessive Thirst ( ) Excessive Urination ( ) Heat/Cold Intolerance

Person completing this questionnaire_____

Relationship to Patient_____

For office use: This questionnaire may be completed by the patient, relatives or ancillary staff provided that it is signed and dated by the treating physician. (Reference may later be made to this information by a signed and dated statement by the treating physician, designating location of the information, date obtained and any subsequent changes.)

Physician's Signature_____Date_____