

NEW PATIENT PAIN ASSESSMENT FORM

Patient Name: _____ DOB: _____ Age: _____

Welcome to our office. Our goal is to provide you with the best possible medical care in a timely manner. Please help us by completing this questionnaire:

MEDICAL HISTORY (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Attention Deficit | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> GI Bleed | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gout | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hepatitis - A / B / C | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cholesterol - High/Low | <input type="checkbox"/> HIV | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Hyper/Hypo Thyroid | <input type="checkbox"/> Skin Rash/Ulcers/Lesions |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> OTHER _____ |
| | <input type="checkbox"/> Lupus | <input type="checkbox"/> NONE |

SURGICAL HISTORY

1. Have you had spinal surgeries? CERVICAL (Neck) THORACIC (Mid-Back) LUMBAR (Low Back)
If so, what type? _____
2. Have you had Facet/Epidural Steroid Injections? CERVICAL(Neck) THORACIC(Mid-Back) LUMBAR
If so, last injection date? _____
3. Do you have a **STENT, PACEMAKER, PORT** or any other **implantable device**? Yes No
If so, what type? _____

ALL OTHER SURGERIES (check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Abdominal Surgery | <input type="checkbox"/> Colon Resection | <input type="checkbox"/> Pneumonectomy |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Craniotomy | <input type="checkbox"/> Prostatectomy |
| <input type="checkbox"/> AV Fistula Creation | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> PTCA |
| <input type="checkbox"/> AV Graft | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> RA-F Bypass |
| <input type="checkbox"/> Aortic Valve Replacement | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Rotator Cuff Repair |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Knee Arthroscopy | <input type="checkbox"/> TURP+ |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> TAH w/ BSO |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Kyphoplasty | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> CABG | <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Carotid Endarterectomy | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Tunneled Dialysis Catheter |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Mitral Valve Replacement | <input type="checkbox"/> UPPP |
| <input type="checkbox"/> Cataract Extraction | <input type="checkbox"/> Nephrectomy Native | <input type="checkbox"/> Vertebroplasty |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Para Thyroidectomy | <input type="checkbox"/> OTHER: _____ |

- Anesthesia Problems: Yes No
 Surgical Complications: Yes No
 Post-OP Complications: Yes No

FAMILY HISTORY (check all that apply):

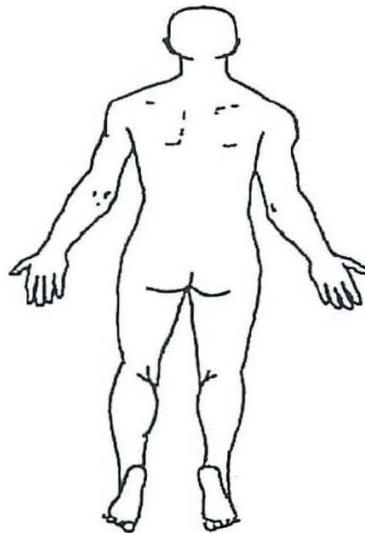
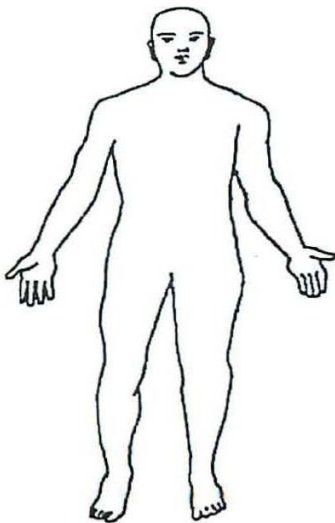
- | | | |
|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cholesterol High/Low | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anesthesia Complications | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Growth Development | <input type="checkbox"/> Severe Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Weight Disorder |

PAIN HISTORY:

- What is your chief complaint for today's visit? _____
- How did the problem begin?: WORK INJURY MOTOR VEHICLE ACCIDENT OTHER
Brief explanation: _____
- How often do you have pain and how long does it last? _____
- Pain is worse WHEN I? _____
- Pain is better WHEN I? _____
- Difficulty sleeping? YES NO
- Problems with daily activities (personal hygiene, house keeping, walking, grocery shopping, etc)? YES NO
- On a scale of 0 to 10 (0=pain free and 10=very painful), pain level right now? _____
- How would you describe your pain? Dull Aching Throbbing Sharp Burning
- Please check below all that applies and write body part:
 Numbness - Where? _____
 Tingling - Where? _____
 Weakness - Where? _____
 Coldness - Where? _____
 Muscle Spasms/Cramps - Where? _____
 Changes on Skin Color - Where? _____

CURRENT PAIN DETAILS

Please use the following symbols to fill in the diagram below:



- N = Numbness
- + = Sharp
- * = Burning
- Δ = Aching
- // = Pins & Needles
- = Shooting
- = Other: _____

Answer the following by circling a number from 0 (no pain) to 10 (worse pain imaginable):

What is your Current pain score (0-10):

0 1 2 3 4 5 6 7 8 9 10

What is your Average pain score (0-10):

0 1 2 3 4 5 6 7 8 9 10

PAIN TREATMENT HISTORY:

1. First medical care date for current problem? _____
2. Please list the names of all doctors you have seen for **this** condition:
 - Doctor _____ Specialty _____ Phone _____
 - Doctor _____ Specialty _____ Phone _____
 - Doctor _____ Specialty _____ Phone _____
 - Doctor _____ Specialty _____ Phone _____
 - Doctor _____ Specialty _____ Phone _____
3. What studies were done?
 - EMG Physician: _____ Most recent date _____
 - MRI Most recent date _____
 - CT scan/Myelogram Most recent date _____
 - X-RAY Most recent date _____
 - DEXA SCAN Most recent date _____
4. Treatments performed:
 - Physical Therapy (circle) US, Ten Unit, Massage, Core Strengthening
 - Exercise Program Relief? _____
 - Chiropractic Manipulation How long? _____
 - Injections IN office _____ OutPatient Procedure _____
 - Psychotherapy/Counseling Results _____
5. **Allergies** to medication? No Yes - Please List: _____
6. Allergies other than medications? No Yes - Please List: _____
7. Please list all of the medications including any over the counter medications, diet supplements, blood thinning medications (Asa, Ecotrin), all herbal (Mai huang, St John's wart), and NSAIDS (Motrin, Ibuprofen, Aleve) medications:

PLEASE LIST ALL INFORMATION REQUESTED

Medication	Doseage	Frequency	Prescribing Physician

- Please be advised, if you have any heart conditions or if you are on Plavix, Coumadin, etc, we will require a written approval from your prescribing physician for discontinuation of these medications prior to scheduling any procedures.
- Please be advised, if you are a diabetic, your blood sugar may increase following steroid injections. Please also note that you need to monitor your blood sugar closely following procedures, and may need assistance at home for 24 hours after injections. Contact your prescribing physician prior to your procedure for specific instructions.

8. Height _____ Weight _____
9. Have you been **prescribed or use any type of OXYGEN** in the past 12 months? If so, explain usage: _____
10. Have you ever seen a psychologist or psychiatrist? Yes No

11. Do you smoke? Yes No How may cigarettes per day? _____
12. If you are a former smoker, when did you quit? _____
13. Do you drink alcohol? Yes No
14. Do you use recreational drugs? Yes No
15. Have you ever had a problem with substance abuse? Yes No
16. Are you currently working? Yes No If not, why? _____
17. Please, briefly describe your job duties: _____
- Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS (check all that apply to you NOW)

<u>GENERAL</u>	<u>EYES</u>	<u>EARS, NOSE, THROAT</u>	<u>CARDIOVASCULAR</u>	<u>RESPIRATORY</u>
<input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> sweats <input type="checkbox"/> anorexia <input type="checkbox"/> fatigue / weakness <input type="checkbox"/> malaise (discomfort) <input type="checkbox"/> weight loss <input type="checkbox"/> weight gain <input type="checkbox"/> sleep disorder	<input type="checkbox"/> blurring <input type="checkbox"/> diplopia (double vision) <input type="checkbox"/> irritation <input type="checkbox"/> discharge <input type="checkbox"/> vision loss <input type="checkbox"/> eye pain <input type="checkbox"/> photophobia	<input type="checkbox"/> earache <input type="checkbox"/> ear discharge <input type="checkbox"/> tinnitus <input type="checkbox"/> decreased hearing <input type="checkbox"/> nasal congestion <input type="checkbox"/> nosebleeds <input type="checkbox"/> sore throat <input type="checkbox"/> hoarseness	<input type="checkbox"/> chest pains <input type="checkbox"/> palpitations <input type="checkbox"/> syncope (fainting) <input type="checkbox"/> dyspnea on exertion (difficulty breathing) <input type="checkbox"/> orthopnea (difficulty breathing lying flat) <input type="checkbox"/> PND (Paroxysmal Nocturnal Dyspnoea) <input type="checkbox"/> peripheral edema	<input type="checkbox"/> cough <input type="checkbox"/> dyspnea (difficulty breathing) <input type="checkbox"/> excessive sputum <input type="checkbox"/> hemoptysis (coughing up blood) <input type="checkbox"/> wheezing <input type="checkbox"/> pleurisy

<u>GASTROINTESTINAL</u>	<u>GENITOURINARY</u>	<u>MUSCULOSKELETAL</u>	<u>DERM / SKIN</u>	<u>NEUROLOGICAL</u>
<input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> change in bowel habits <input type="checkbox"/> abdominal pain <input type="checkbox"/> melena (black, tarry stools) <input type="checkbox"/> hematochezia (vomiting of blood) <input type="checkbox"/> jaundice <input type="checkbox"/> gas / bloating <input type="checkbox"/> indigestion / heartburn <input type="checkbox"/> dysphagia (difficulty swallowing) <input type="checkbox"/> odynophagia (painful swallowing)	<input type="checkbox"/> dysuria (painful urinating) <input type="checkbox"/> hematuria (blood in urine) <input type="checkbox"/> discharge <input type="checkbox"/> urinary frequency <input type="checkbox"/> urinary hesitancy <input type="checkbox"/> nocturia (excessive urination at night) <input type="checkbox"/> incontinence <input type="checkbox"/> genital sores <input type="checkbox"/> decreased libido <input type="checkbox"/> erectile dysfunction	<input type="checkbox"/> back pain <input type="checkbox"/> neck pain <input type="checkbox"/> joint pain <input type="checkbox"/> joint swelling <input type="checkbox"/> muscle cramps <input type="checkbox"/> muscle weakness <input type="checkbox"/> stiffness <input type="checkbox"/> arthritis <input type="checkbox"/> sciatica <input type="checkbox"/> restless legs <input type="checkbox"/> leg pain at night <input type="checkbox"/> leg pain with exertion	<input type="checkbox"/> rash <input type="checkbox"/> itching <input type="checkbox"/> dryness <input type="checkbox"/> suspicious lesions	<input type="checkbox"/> paralysis <input type="checkbox"/> paresthesias (burning or prickling in hands, arms, legs, feet, etc) <input type="checkbox"/> seizures <input type="checkbox"/> tremors <input type="checkbox"/> vertigo <input type="checkbox"/> transient blindness <input type="checkbox"/> frequent falls <input type="checkbox"/> frequent headaches <input type="checkbox"/> difficulty walking

<u>PSYCHOLOGICAL</u>	<u>ENDOCRINE</u>	<u>HEMATOLOGICAL/LYMPHATIC</u>	<u>ALLERGY / IMMUN</u>
<input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> memory loss <input type="checkbox"/> suicidal ideation <input type="checkbox"/> hallucinations <input type="checkbox"/> paranoia <input type="checkbox"/> phobia <input type="checkbox"/> confusion	<input type="checkbox"/> cold intolerance <input type="checkbox"/> heat intolerance <input type="checkbox"/> polydipsia (excessive thirst) <input type="checkbox"/> polyphagia (excessive hunger) <input type="checkbox"/> polyuria (excessive amount of urine production) <input type="checkbox"/> unusual weight change	<input type="checkbox"/> abnormal bruising <input type="checkbox"/> bleeding <input type="checkbox"/> enlarged lymph nodes	<input type="checkbox"/> urticarial (hives) <input type="checkbox"/> allergic rash <input type="checkbox"/> hay fever <input type="checkbox"/> recurrent infections