PREMIER PAIN CONSULTANTS

Office Use Only	
Blood Pressure:	___________
Heart Rate:	___________
Temperature:	___________
Weight:	___________
SPO2:	___________
BMI:	___________
Height	___________

Name:____

DOB:_______________________

Who is your primary care physician/family doctor?

____

How did you hear about our office?

( )Physician ( ) Insurance ( )Yelp ( ) Google ( ) Other____________

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

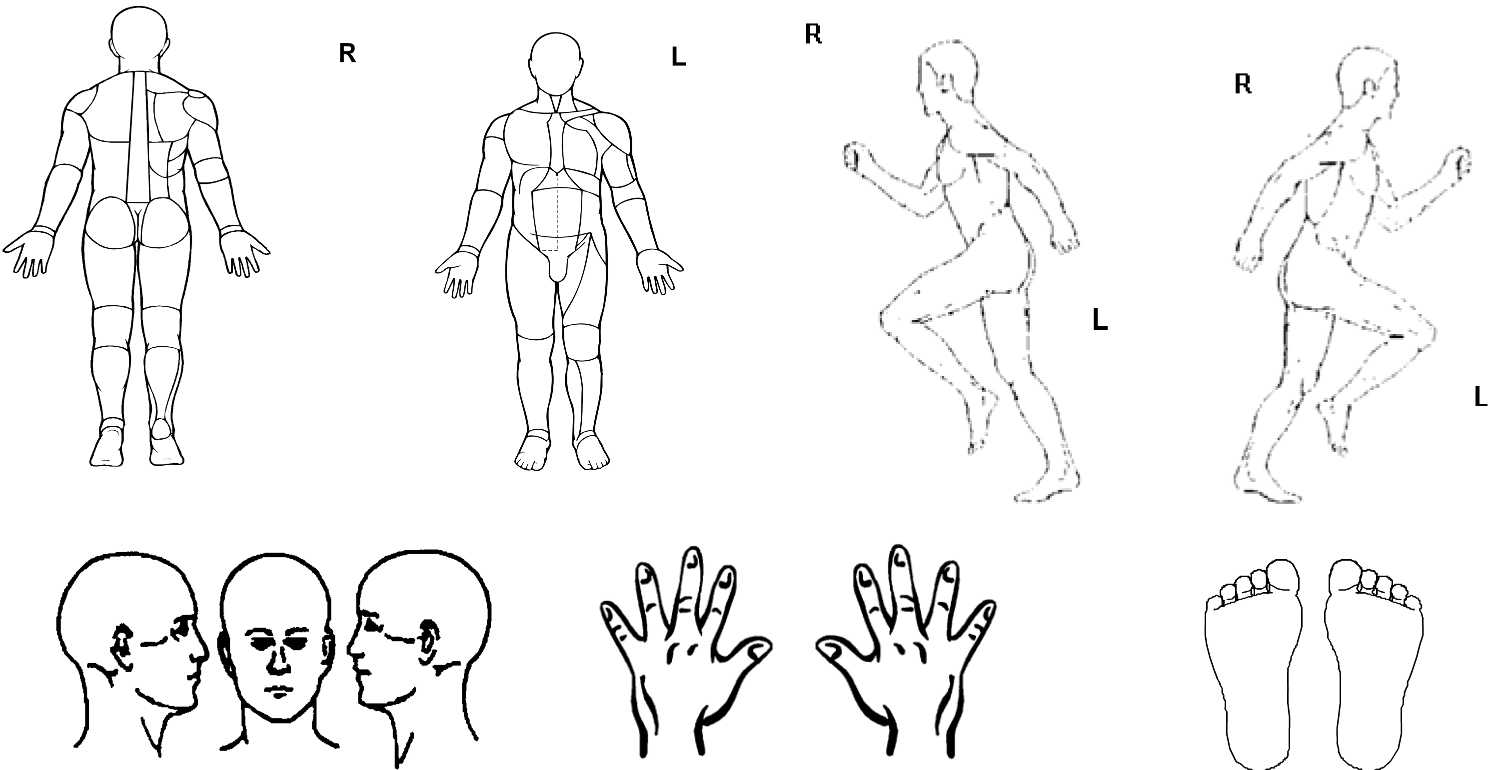
____

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

In what time period is your pain worst? ( ) early morning ( ) late evening

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. _________________

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 ( ) Chiropractor ( ) Pain Management
( ) Acupuncturist ( ) Alternative medicine ( ) Other, please list ___________________

Which of the following tests have you undergone prior to your arrival here today?
( ) X-rays ( ) MRI scan ( ) CAT scan ( ) ultrasound ( ) EMG test ( ) Discogram/Discography

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

Name of medication	Yes	No	Effectiveness (0-10)
Tylenol/acetaminophen			
NSAID's: Advil/Motrin/Advil/Ibuprofen,etc			
Oral Steroids: Medrol dose pack/Prednisone, etc			
Amitriptyline (Elavil)/Nortriptyline (Pamelor), etc			
Muscle relaxants: Flexaril/Soma/Robaxin/Tizanidine, etc			
Nerve Pain: Neurontin(Gabapentin)/Topamax/Tegretol/Cymbalta, Lyrica, etc			
Benzodiazepines: Xanax/Ativan/Valium,etc			
Opioids: Hydrocodone (Norco)/Oxycodone/Morphine/Fentanyl/Dilaudid, etc			
Illicit drugs: Cocaine/Herion, etc			
Cannabis: THC/CBD, etc			
Others, please list			

Have you had any of the following treatments for your pain?

Treatment	Yes	No	Effectiveness (0-10)	% of Relief	Dates
TENS/nerve stimulator					
Physical Therapy					
Trigger point injections					
Epidural Steroid injections					
Nerve block injections (not steroids)					
Other, please list:					

PAST MEDICAL HISTORY

Please list the medications you are currently taking:

Name	Dosage	How Often?

Drug and Food **ALLERGIES**: ____
____

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

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__________________________________