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When you come for your first visit, you must bring any medical records; x-rays, CT, and/or MRI images with report; list of medications; and any other relevant medical information related to your acute or chronic pain problem.

Name: Date of Birth: Phone:

Email address: Pharmacy Name & Phone:

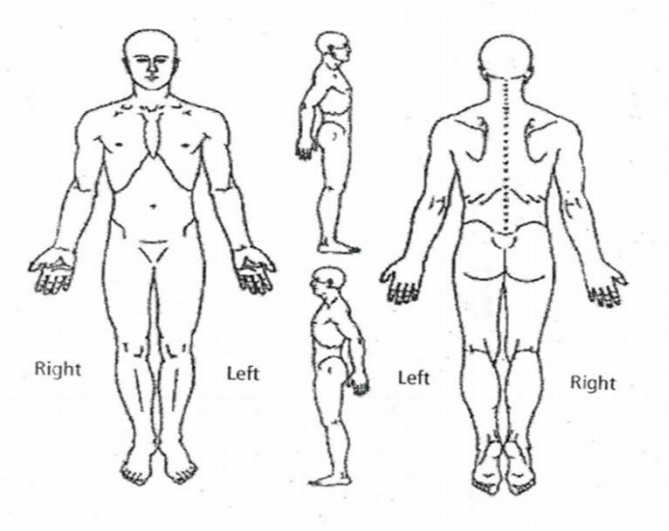
Primary Care Physician Name: _____ Phone: _____ Fax: _____

Address: _____ City/State: _____ Zip: _____

Referring Physician Name: _____ Phone: _____ Fax: _____

Address: _____ City/State: _____ Zip: _____

Please mark your pain



What are your activity goals for your pain treatment?

1) _____

2) _____

3) _____

How long have you had chronic pain? *Month/year:*

Please describe events surrounding the onset of your pain.
(i.e. date of injury, activities that made it worse?)

_____

_____

_____

_____

In the last 12 months, how many ER visits have you had for your pain? (please circle) 0 1 2 3 5 – 10 >10

Which words best describe your pain: (circle all that apply)

Throbbing Cramping Heavy/Pressure Tingling/ Pins & needles Cold/ Freezing
Hot/ Burning Electric/Shock Shooting Stabbing Itching Numbness

What activities make your pain WORSE: (circle all that apply)

Rest Touch Sitting Standing Bending Lifting Walking Light exercise Sex Warm compresses
Cold compresses Relaxation techniques Other:

What activities make your pain BETTER: (circle all that apply)

Rest Touch Sitting Standing Bending Lifting Walking Light exercise Sex Warm compresses
Cold compresses Relaxation techniques Other:

Relief (%) You've had in the last 24 hours from medications and/or treatments:

No Relief 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% Complete Relief 100%

When taking your medication, how long do you get relief: ____ Hours ____ Minutes No help at all. I do not take medications

Does your pain affect your sleep? YES / NO **Does your pain cause depression?** YES / NO

Does your pain cause anxiety? YES / NO **Do you see a therapist or psychologist?** YES / NO If so, who:

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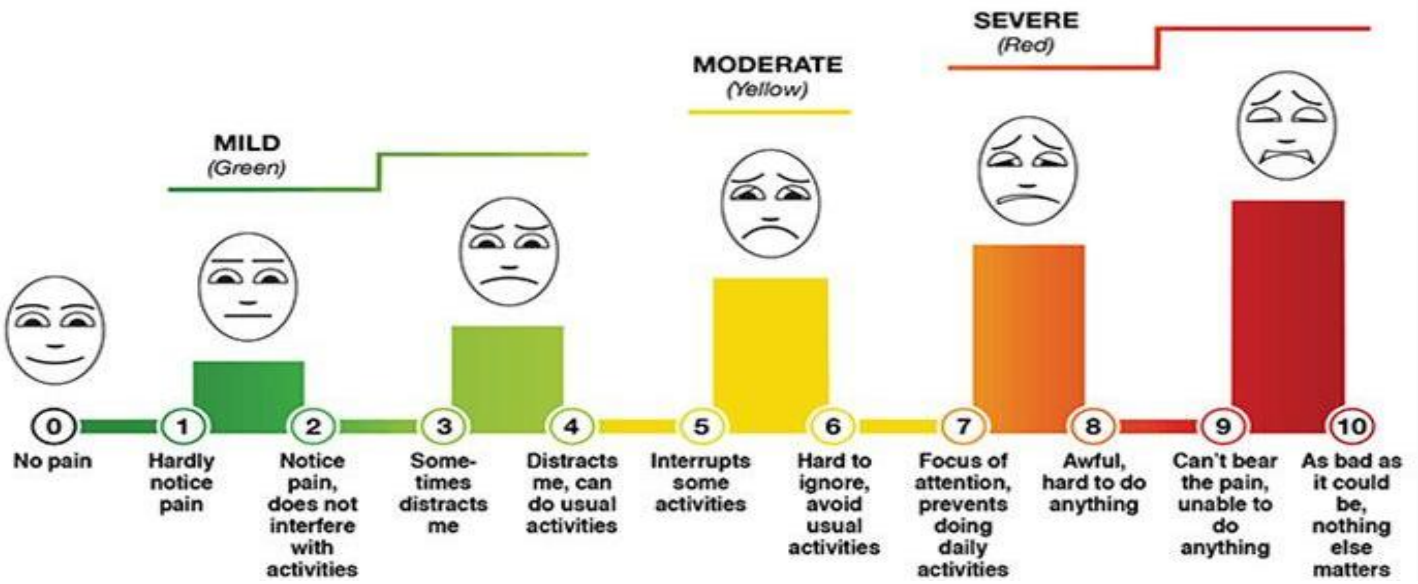

USING THE FIGURE ABOVE, PLEASE ANSWER THE FOLLOWING QUESTIONS

Please write the number that indicates your WORST PAIN LEVEL over the last week: _____

Please write the number that indicates your LEAST PAIN LEVEL over the last week: _____

Please write the number that indicates your AVERAGE PAIN LEVEL over the last week: _____

Please write the number that indicates your CURRENT PAIN LEVEL over the last week: _____

PLEASE HELP US UNDERSTAND HOW PAIN HAS INTERFERED WITH YOUR:

General Activity
Does NOT interfere 0 1 2 3 4 5 6 7 8 9 10 *Interferes Completely*

Mood
Does NOT interfere 0 1 2 3 4 5 6 7 8 9 10 *Interferes Completely*

Walking Ability
Does NOT interfere 0 1 2 3 4 5 6 7 8 9 10 *Interferes Completely*

Ability to perform tasks at home or at work
Does NOT interfere 0 1 2 3 4 5 6 7 8 9 10 *Interferes Completely*

Relations with other people
Does NOT interfere 0 1 2 3 4 5 6 7 8 9 10 *Interferes Completely*

Sleep
Does NOT interfere 0 1 2 3 4 5 6 7 8 9 10 *Interferes Completely*

Enjoyment of life
Does NOT interfere 0 1 2 3 4 5 6 7 8 9 10 *Interferes Completely*

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Other Symptoms: Please CIRCLE those you've had DURING THE PAST MONTH

General	Eyes	Gastrointestinal	Bleeding/ Allergic
Fever	Blurred Vision	Heartburn	Bruise easily
Chills	Double Vision	Nausea	Bleeding easily
Weight Loss	Sensitivity to light	Vomiting	Environmental allergies
Weight Gain	Eye pain	Abdominal Pain	Increased thirst
Fatigue	Eye drainage	Diarrhea	
Weakness	Eye redness	Constipation	
Sweating		Blood in stool	
		Black stool	

Neurologic	Skin	Head, Ears, Nose, Throat	Cardiovascular
Dizziness	Rash	Headache	Chest pain
Tremor	Itching	Hearing change	Rapid heartbeat
Change in sensation		Ears ringing	Irregular heartbeat
Change in speech		Ear pain	Lying down – short of breath
Focal weakness		Ear drainage	Leg swelling
Changes in alertness		Nosebleeds	
		Congestion	

Respiratory	Urinary	Musculoskeletal	Psych
Cough	Pain	Muscle aches	Depression
Productive cough	Urgency	Low back pain	Suicidal thoughts
Coughing blood	Frequency	Neck pain	Hallucinations
Short of breath with exertion	Urinary incontinence	Joint pain	Nervous/ Anxious
Wheezing	Blood in urine	Falls	Irritability
	Flank pain		Insomnia
	Pelvic pain		Memory problems

Have you ever experienced (current or past):

Treatment for mood, anxiety, and/or sleep disorders?	YES / NO
Nightmares or flashbacks from prior traumatic experiences?	YES / NO
Alcohol, illicit drug, or prescription medication misuse/ addiction?	YES / NO
Problems with compulsive behaviors such as gambling, eating disorder, etc?	YES / NO
Hospitalization for anxiety or depression?	YES / NO
Hospitalization for any other psychologic disorder?	YES / NO

If so, please explain:

How many physicians have been involved in the treatment of your pain? (please circle)

0 – 3 4 – 6 7 – 10 11 – 15 16 – 20

Have you ever been discharged from a pain clinic for any reason? YES / NO

If yes, please give their name(s) and reason(s) for dismissal:

_____

_____

_____

Name the last physician or clinic where you received treatment for chronic pain? _____

Why are you no longer being treated there? _____

_____

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Pain Management Procedures that You've Had

		How Many	Date(s) performed *(approximate)*
☐	Trigger Point Injections	_____	_____
☐	Medial Branch Nerve Blocks	_____	_____
☐	Radiofrequency Nerve Ablation or Rhizotomy	_____	_____
☐	Epidural Steroid Injections	_____	_____
☐	Caudal Steroid Injection	_____	_____
☐	Spinal Cord Stimulator Trial	_____	_____
☐	Spinal Cord Stimulator Implant	_____	_____
☐	Facet Joint Injection	_____	_____
☐	Sacroiliac (SI) Joint Injection	_____	_____
☐	Stellate Ganglion Block	_____	_____
☐	Lumbar Sympathetic Block	_____	_____
☐	Intercostal Nerve Block	_____	_____
☐	Knee Genicular Nerve Block	_____	_____
☐	Occipital Nerve Block	_____	_____
☐	Botox Injection	_____	_____
☐	Kyphoplasty/ Vertebroplasty	_____	_____

Past Medical History: Please list any major illnesses or injuries you have experienced over the course of your life.

_____

_____

_____

Past Surgical History: Please list any surgeries with year you have had over the course of your life.

_____

_____

_____

Allergies: Please list any allergies and reaction you have. Include medications and other non-medication allergies.

_____

_____

_____

Are you allergic to shellfish? YES / NO Are you allergic to Iodine or IV contrast dye? YES / NO

Education: (Please circle the highest level of education you have completed)

Grade School High School Junior/Community College Trade school Some college/University

Graduated College/University Graduate/ Professional school

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Family History

Please list family members' illnesses and their relation to you *(i.e. cancer, diabetes, psychological, substance abuse, etc; mother, father, sister, grandfather, etc)* : _____

_____

_____

Any family members have or had alcohol, illicit drug or prescription medication misuse/ addiction? YES / NO

Problems with compulsive behaviors such as gambling, eating disorder, or other? YES / NO

Does anyone in your household take prescription pain medication? YES / NO

Does anyone in your household use illicit drugs? YES / NO

Social History

Marital Status: Single Married Separated Divorced Widowed

Who lives at home with you? _____

Describe your level of family support? Strong Average Minimal None

Your sources of enjoyment and/or support (family, friends, hobbies)? _____

What are your sources of stress (family, finances, home situation, etc)? _____

Do you experience mental, physical, or emotional abuse from anyone? YES / NO Do you need assistance? YES / NO

Are you involved in an Auto claim? YES / NO Is there litigation pending? YES / NO

Is spirituality and/or religion an important role in your life? YES / NO _____

Employment

Work Status: Full-time employment Part-time employment Student Unemployed Retired Disabled

If employed: Occupation: _____ # hours/day _____ # days/week _____

If not currently employed, when did you last work? _____ What was your most recent job? _____

If receiving disability benefits, when did they begin? *(month/year)* _____

Are you involved in a Worker's Compensation claim? YES / NO Is there litigation pending? YES / NO

Substance Use

Do you smoke cigarettes? YES / NO # Packs/day _____ # years _____

Former smoker? YES / NO # packs/day _____ # years _____

Do you drink alcohol? YES / NO # drinks/day _____ # years consuming alcohol _____

Do you use illegal drugs? YES / NO Which substances? _____ How often? _____ # years? _____

Have you ever had a problem with alcohol, illicit drugs, or prescription meds? YES / NO If yes, please explain: _____

_____

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Have you ever:

Had prescription pain medications lost or stolen? YES / NO

Shared your prescription pain medication with others (family, friends, roommate, etc)? YES / NO

Taken more of your prescription pain medication than has been prescribed? YES / NO

Have you run out of your prescription pain medication early/ before it was due to be refilled? YES / NO
How often has this occurred? _____

Taken prescription pain medications to relieve non-pain symptoms (anxiety, sleep, etc)? YES / NO

Taken prescription pain medications that were not prescribed to you (from family, friend, coworker, etc)? YES / NO

Altered a prescription pain pill for enhanced effort (such as crushing a time-released tablet)? YES / NO

Been in a treatment program alcohol or drug abuse? YES / NO

Attended a 12 step meeting such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)? YES / NO

Had a DUI or been arrested for using, selling, or stealing illicit drugs or prescription medications? YES / NO

Had a drug overdose? YES / NO

Had someone express concern about your overuse of prescription pain medications, drugs, or alcohol? YES / NO

If you answered "YES" to any of the above, please explain: _____

_____

_____

Past Medications that you've tried: Please indicate Dosage, Benefits, and Side Effects.

Medication	**Dose and Frequency**	**Benefits**	**Side Effects**
Anti-Inflammatory (NSAID's)			
Ibuprofen (Motrin, Advil)			
Naproxen (Aleve, Naprosyn, Anaprox)			
Meloxicam (Mobic)			
Celecoxib (Celebrex)			
Toradol (Ketorolac)			
Narcotic Pain Medications			
Propoxyphene (Darvocet)			
Ultram (Tramadol)			
Codeine (Tylenol #3)			
Meperidine (Demerol)			
Hydromorphone (Dilaudid)			
Fentanyl (Duragesic) Patch			
Morphine (MS Contin, Kadian, Avinza)			
Hydrocodone (Lorcet, Lortab, Vicodin)			
Methadone (Dolophine)			
Oxycodone ER (Oxycontin)			
Oxycodone (Percocet, Roxycodone)			
Butorphanol (Stadol)			
Pentazocine (Talwin)			
Buprenorphine (Suboxone, Subutex)			

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"Membrane Stabilizers"

Gabapentin (Neurontin)	_____	_____	_____
Pregabalin (Lyrica)	_____	_____	_____
Valproate (Depokote)	_____	_____	_____
Carbamazepine (Tegretol)	_____	_____	_____
Topiramate (Topamax)	_____	_____	_____
Lamotrigine (Lamictal)	_____	_____	_____

"Anti-Depressants"

Amitriptyline (Elavil)	_____	_____	_____
Imipramine (Tofranil)	_____	_____	_____
Desipramine (Norpramin)	_____	_____	_____
Doxepin (Sinequan)	_____	_____	_____
Nortriptyline (Pamelor)	_____	_____	_____
Milnacipran (Savella)	_____	_____	_____
Duloxetine (Cymbalta)	_____	_____	_____
Venlafaxine (Effexor)	_____	_____	_____
Desvenlafaxine (Pristiq)	_____	_____	_____
Prozac (Fluoxetine)	_____	_____	_____
Paroxetine (Paxil)	_____	_____	_____
Trazodone (Desyrel)	_____	_____	_____
Bupropion (Wellbutrin)	_____	_____	_____

Benzodiazepines "Minor Tranquilizers"

Diazepam (Valium)	_____	_____	_____
Clonazepam (Klonopin)	_____	_____	_____
Alprazolam (Xanax)	_____	_____	_____
Lorazepam (Ativan)	_____	_____	_____

Muscle Relaxants

Baclofen (Lioresal)	_____	_____	_____
Carisoprodol (Soma)	_____	_____	_____
Cyclobenzaprine (Flexeril)	_____	_____	_____
Methocarbamol (Robaxin)	_____	_____	_____
Metazalone (Skelaxin)	_____	_____	_____
Tizanidine (Zanaflex)	_____	_____	_____

"Local" or "Topical" (applied to skin)

Diclofenac (Voltaren Gel)	_____	_____	_____
Lidoderm Patch (Over the counter)	_____	_____	_____
Lidoderm Patch (prescription)	_____	_____	_____
Flector Patch	_____	_____	_____
Capsacian	_____	_____	_____
Salonpas, Icy Hot, Bengay or Tiger Balm	_____	_____	_____

Any additional information you'd like to share with our Pain Management team? _____

_____

_____

_____

Thank you for completing this form in its entirety. We look forward to the opportunity to participate in your care.