PAIN MANAGEMENT

Pain Institute of Southern Arizona

The information requested on this from will be very helpful to us in working out with you the best treatment program for your pain. Please answer each question and add additional comments if you feel they would be helpful.

Date:_____

I.

Name:_____

Home Phone:_____

Employer/Occupation_____

Referring Physician:_____

Height:_____Weight:_____Age_____

Date of Birth:_____Language_____

Race/Ethnicity:_____

Job status: ☐ full time ☐ part time ☐ unemployed ☐ disability

If currently employed, how much work have you missed in the last month due to pain?_____

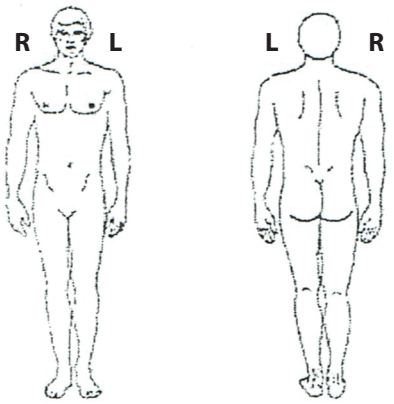
Reason for visit:_____

Have you found it necessary to seek legal counsel in any health related matters? ☐ Yes ☐ No

If yes, please explain:_____

II. PAIN DESCRIPTION & FACTORS INFLUENCING PLAN

Please shade in on the drawing the areas where you feel pain.



1. When did your pain start?_____

2. How did your pain first start? (accident, etc.)

_____

3. Describe in your own words what your pain is like (how it feels):

☐ burning ☐ ache ☐ throb ☐ cramping
☐ electric ☐ dull ☐ sharp ☐ shooting
☐ stabbing ☐ numb ☐ tender
☐ other_____

4. How frequently do you have pain? (check those that apply)

☐ constant ☐ comes and goes ☐ sometimes worse than others
☐ other_____

5. Our pain program uses a pain scale of 0-10 as a measure of increasing intensities as represented by the following:

0	1	2	3	4	5	6	7	8	9	10
No pain					Moderate Pain					Severe Pain

A. To answer each question below; write number most appropriate in the space beside the question:
   1. Which number describes your pain right now?_____
   2. Which number describes your pain at its worst?_____
   3. Which number describes your pain at its least?_____

B. Which of the following helps reduce your pain? Check all that apply:
   ☐ heat ☐ cold ☐ rest ☐ pacing ☐ standing ☐ sitting
   ☐ doing some activity other_____

C. What increases your pain? Check all that apply:
   ☐ sitting ☐ pushing ☐ activity (moving around) ☐ damp weather
   ☐ cold ☐ tension ☐ lifting ☐ standing
   ☐ lying down ☐ walking -- how long can you walk? _____
   ☐ other_____

PLEASE FILL OUT THE BACK SIDE OF THIS FORM

III. PREVIOUS TREATMENT FOR PAIN

Which, if any of the following treatments have you had for your pain problem?

Treatment: ☐ Nerve Blocks ☐ Surgery ☐ TENS Unit ☐ Biofeedback
☐ Behavioral Therapy ☐ Occupational/Physical Therapy ☐ Epidural Steroid
☐ Other_____

How helpful were any of the treatments(s) ☐ Very ☐ Somewhat ☐ Not at all

Diagnostics: Which of the following lab tests have you had to evaluate your pain problem?

(Date of Test / Where performed) *(Date of Test / Where Performed)*

X-Rays_____ MRI_____
Lab Tests (blood, urine)_____ EMG_____
CT Scans_____ Other_____

IV. MEDICATIONS

A. Current Medications: List all medications(s) you are now taking (include dose/frequency)

_____ _____
_____ _____
_____ _____
_____ _____

B. Past medications used for pain:

Medication *Why was it stopped?*

_____ _____
_____ _____

C. Surgeries: List past surgeries in the spaces below, including month/year surgery was performed:

_____ _____
_____ _____

D. Allergies: List all allergies you may have and the reaction you experience:

1. Iodine allergy ☐ Yes ☐ No

2. List other allergies_____

_____

_____/_____ Questionnaire reviewed with patient: _____/_____
Signature of patient *Date* *Signature of patient* *Date*

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