

Pain Management New Patient Consultation

For Doctors use only

Name: _____ Today's Date: _____

DOB: _____ Age: _____ Sex: M or F SSN: _____ - _____ - _____

Home Address: _____

City: _____ State: _____ Zip: _____

Vitals BP: _____/_____ P: _____ HT: _____" WT: _____

Work Status: **Full-Part-Disabled-Retired-Other:** _____ BWC Yes/No

Do you receive disability income because of your illness/injury? **Yes/No**

Are you involved in any lawsuits due to your pain condition? **Yes/No**

Insurance Provider: _____

Referring Physician: _____ Phone Number: _____

Address: _____ City: _____ Zip: _____

Reason for Referral: _____

History of Present Illness

1) Please mark the location (s) of your pain:

- Head
- Face
- Neck
- Shoulder
- Arm
- Hand
- Wrist
- Chest
- Abdomen
- Upper back
- Lower back
- Hip
- Buttock
- Leg(s)
- Ankle
- Foot
- Genitals /Rectum
- Other

Also, describe the quality of the pain. Circle the best choice(s)

Constant Intermittent Aching Dull Throbbing Cramping Stabbing Stinging
Burning Radiating

Color Change: _____ Numbness: _____ Swelling: _____

2) Of the pain problems marked above, please list them below in order of greatest concern to you and state how long you have had each pain problem.

#1 area of pain: _____ How long? _____

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#2 area of pain: _____ How long? _____

#3 area of pain: _____ How long? _____

3) In what part(s) of the body did the pain begin? _____

4) Under what circumstances did this pain start? _____

- Accident: _____ at work _____ at home _____ automobile
- At work, but not an accident
- Following a surgery
- Following an illness
- Pain just began without an apparent cause
- Other: _____

5) What have you been told by your physician or other health professionals, is the cause of this pain? _____

6) What is your pain at this moment? (0 represents no pain and 10 is the worst imaginable pain)

None 0 1 2 3 4 5 6 7 8 9 10 Worst

7) In the past 6 months, how would you rate your pain, on average, from 0-10?

None 0 1 2 3 4 5 6 7 8 9 10 Worst

8) In the past 6 months, how much has your pain changed your ability to take part in recreational, social, and family activities? Use the scale below, 0 being no change 10 being an extreme change.

None 0 1 2 3 4 5 6 7 8 9 10 Extreme Change

9) When is your pain the worst? (Check all that apply)

Lying down Sitting Standing Walking Bending
 Twisting
 Morning Evening Bedtime Other: _____

10) Do you feel helpless to change your present condition?

Never Sometimes Most of the time Always

11) Do you ever feel your condition is hopeless?

Never Sometimes Most of the time Always

12) On Average, how many hours of sleep do you receive per night? _____

How many times does the pain wake you up at night? _____

Do you return to sleep easily? **Yes/No**

Do you have trouble falling asleep at night?

Always Often Sometimes Not very often Never

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Test (List when most recent was done)

MRI: _____ X-Ray: _____ CT: _____
 EMG: _____ Bone Scan: _____ Myelogram: _____

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Medical History

1) Please indicate whether you (or any family member) have currently, or have had in the past, any of the following medical conditions:

Condition	You (check)	Current	Family(check)	Who?	Current
Alcoholism		Yes No			Yes No
Arthritis		Yes No			Yes No
Asthma		Yes No			Yes No
Cancer Where		Yes No			Yes No
Chronic Neck/back pain		Yes No			Yes No
Diabetes		Yes No			Yes No
Drug Abuse		Yes No			Yes No
Depression/Anxiety		Yes No			Yes No
Epilepsy		Yes No			Yes No
Headaches		Yes No			Yes No
Heart Trouble		Yes No			Yes No
Hepatitis		Yes No			Yes No
High Blood Pressure		Yes No			Yes No
Kidney Disease		Yes No			Yes No
Phlebitis		Yes No			Yes No
Pneumonia		Yes No			Yes No
Polio		Yes No			Yes No
Rheumatic Fever		Yes No			Yes No
Sexually transmitted Disease		Yes No			Yes No
Stroke		Yes No			Yes No
TB/ Lung Disease		Yes No			Yes No
Thyroid Disease		Yes No			Yes No
Ulcers		Yes No			Yes No

Indicate any other medical condition you now have or have had that was not listed above: _____

Surgical History

1) Have you had any surgery for your pain disorder? **Yes/No**

Describe them below: (also include epidural steroid injections, trigger point injections, nerve blocks etc...)

2) List all surgeries you have had other than your pain procedures: (include type, date and what doctor) _____
