NOTIFICATION: Please be aware that we participate in the Prescription Monitoring Program and can access your prescription record.

Where are you having pain? _________________________________________________________

PLEASE SHADE IN THE LOCATION OF YOUR PAIN.

When did the pain start? ____________________________________________________________

Did you have a fall or an accident that caused the pain? □ yes □ no  If yes, please describe the situation.

Have you had similar pain in the past? □ yes □ no If yes, what was done for the pain?

Were you injured on the job? □ yes □ no

What is your current pain score?  No pain  0  1  2  3  4  5  6  7  8  9  10

What is your worst pain score?  No pain  0  1  2  3  4  5  6  7  8  9  10

Please mark the word or words that describe your pain:

☐ Constant ☐ Aching ☐ Pins and Needles ☐ Muscle Spasms
☐ Intermittent (comes and goes) ☐ Throbbing ☐ Stabbing ☐ Muscle Tightness
☐ Sharp ☐ Numbness ☐ Burning
☐ Dull ☐ Tingling ☐ Shooting

What improves your pain? (i.e. medication, heat, cold, sitting, lying down, relaxation, etc.)

What makes your pain worse? (i.e. walking, standing, lifting, bending, etc.)
What medications are you CURRENTLY taking for pain? __________________________________
________________________________________________________________________________

What medications have you taken in the past for pain? (Motrin, Advil, Aleve, Tylenol, Relafen, Voltaren, Vicodin, Percocet, Norco, prednisone, steroids, Neurontin, amitriptyline, Flexeril, Robaxin etc.) __________________________________________________________________________
_______________________________________________________________________________

Do you take medications that thin out your blood or make you bleed easier such as Coumadin, plavix, aspirin, aggrenox, Xarelto, Lovenox, or Pradaxa? □ yes □ no ______________________________

Have you had physical therapy, acupuncture, or chiropractic manipulation? □ yes □ no If yes, please list when and where it was done. ____________________________________________________________

Have you received care from another pain management clinic? □ yes □ no If yes, please list the name of the clinic and physician?____________________________________________

Have you had injections to help with your pain? □ yes □ no If yes, please list the type of injection, when, and where it was done. __________________________________________________________
________________________________________________________________________________

Which hand is dominant? left right ambidextrous (both hands)

Which of the following tests have been done to evaluate the pain area that you are being seen for today? X-ray MRI CT scan Ultrasound EMG other______________________________

REVIEW OF SYSTEMS: Please mark any problems or symptoms you have from the list below.

CONSTITUTIONAL: □ fever □ chills □ weight loss □ weight gain □ difficulty sleeping
□ fatigue □ history of cancer

SKIN: □ rash □ itching

HENT: □ headache □ hearing loss

EYES: □ blurred vision □ double vision □ glaucoma

CARDIOVASCULAR: □ heart problems □ chest pain □ racing heart beat
□ swelling in the legs

RESPIRATORY: □ shortness of breath □ cough □ sleep apnea

GASTROINTESTINAL: □ liver disease □ hepatitis □ loss of bowel control □ diarrhea
□ constipation □ stomach ulcer

GENITOURINARY: □ loss of bladder control □ changes in bladder control □ kidney stones
□ kidney disease

MUSCULOSKELETAL: □ joint pain □ arthritis □ back pain □ neck pain

ENDO/HEME/I.D. □ easy bleeding □ easy bruising □ thyroid disease □ diabetes
□ infection

NEUROLOGICAL: □ seizures □ stroke □ memory problems □ peripheral neuropathy
□ head injury □ weakness □ saddle anesthesia (no sensation in the crotch region)

PSYCHIATRIC: □ depression □ anxiety □ substance abuse
PERSONAL BACKGROUND:

What are your medical problems? _____________________________________________________
________________________________________________________________________________

What surgeries have you had? _______________________________________________________
________________________________________________________________________________

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widow       Number of Children _______

What is your occupation? _______________  □ Full Time  □ Part Time  □ Unemployed  □ Retired

If retired, previous occupation? _______________

Are there limitations at work? □ yes □ no  If yes, what are they? ______________________________

Describe job tasks that affect your pain. ________________________________________________

Is there litigation involved? □ yes □ no  Is this a worker's compensation case? □ yes □ no

Do you use tobacco products? □ yes □ no  □ Cigarettes □ Pipe □ Cigars □ Chew

Packs/Day ________  If former tobacco user, when did you quit? _______________

Do you drink alcohol? □ yes □ no  If yes, how many drinks per week? ________________

Do you use recreational drugs? □ yes □ no  If yes, what type and how much? ______________

Do you currently exercise? □ yes □ no  If yes, what type? _______________________________

Are you able to do the following activities of daily living yourself? Please check all that apply.

□ Eat □ Bathe □ Toilet □ Dress □ Stand up from sitting position

What medical problems do your parents and siblings have?

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<th>Mother</th>
<th>Father</th>
<th>Sister</th>
<th>Brother</th>
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<td>Cancer</td>
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<td>Substance Abuse</td>
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<td>Alcohol Abuse</td>
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Allergies

Contrast dye allergy: □ yes □ no  Latex allergy: □ yes □ no

PLEASE REVIEW AND UPDATE THE ATTACHED MEDICATION LIST.

Are there changes? □ yes □ no