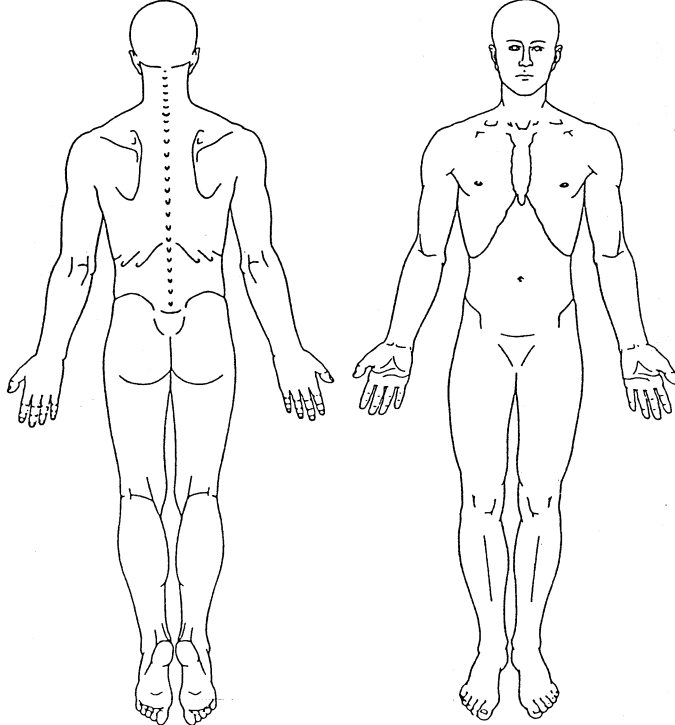


Name		Today's date	<b>THIS COLUMN FOR OFFICE STAFF USE ONLY. ↓</b>  CC & HPI timing 1/4 duration 2/4 location 3/4 quality 4/4 context 5/4 modifying factors 6/4 severity 7/4 sleep
Date of birth	Primary care physician		
Age	Referring physician		
<p><b>WHERE</b> is your pain? Color the areas on this diagram where your pain has been for the <b>last 2-3 weeks</b>:</p> <p><b>RED</b> = Excruciating pain  <b>GREEN</b> = Moderate pain  <b>BLUE</b> = Severe pain  <b>YELLOW</b> = Mild pain</p>			
<p><b>WHEN</b> did your pain start?</p>			
<p>In the last 2-3 weeks, <b>WHEN</b> does your pain occur?</p> <input type="checkbox"/> intermittent (on/off) <input type="checkbox"/> 8-16 hrs/day <input type="checkbox"/> less than 8 hrs/day <input type="checkbox"/> constant			
<p><b>HOW</b> did your pain start?</p> <input type="checkbox"/> auto accident <input type="checkbox"/> work related <input type="checkbox"/> after surgery <input type="checkbox"/> fall (not at work) <input type="checkbox"/> other, describe: <hr style="border-top: 1px dotted black;"/> <hr style="border-top: 1px dotted black;"/>			
<p><b>WHAT</b> does your pain feel like? (check all that apply)</p> <input type="checkbox"/> burning <input type="checkbox"/> mild <input type="checkbox"/> sharp <input type="checkbox"/> moderate <input type="checkbox"/> dull <input type="checkbox"/> severe <input type="checkbox"/> stabbing <input type="checkbox"/> aching <input type="checkbox"/> cramping <input type="checkbox"/> other, describe: <hr style="border-top: 1px dotted black;"/> <hr style="border-top: 1px dotted black;"/>	<p>What has been used to <b>TREAT</b> your pain? (check all that apply)</p> <input type="checkbox"/> medications <input type="checkbox"/> individual psychotherapy <input type="checkbox"/> other Pain Center <input type="checkbox"/> biofeedback <input type="checkbox"/> group psychotherapy <input type="checkbox"/> physical therapy <input type="checkbox"/> injections <input type="checkbox"/> relaxation training <input type="checkbox"/> occupational therapy <input type="checkbox"/> treatments in emergency room (ER) - how many times have you been to the ER for pain control over the last 3 months? _____ <input type="checkbox"/> other, describe: <hr style="border-top: 1px dotted black;"/> <hr style="border-top: 1px dotted black;"/>		
<p>What <b>DECREASES</b> your pain? (check all that apply)</p> <input type="checkbox"/> sitting <input type="checkbox"/> bending <input type="checkbox"/> heat <input type="checkbox"/> relaxation exercises <input type="checkbox"/> medications <input type="checkbox"/> standing <input type="checkbox"/> lying flat <input type="checkbox"/> cold <input type="checkbox"/> rest <input type="checkbox"/> injections <input type="checkbox"/> walking <input type="checkbox"/> not working <input type="checkbox"/> physical therapy <input type="checkbox"/> other, describe:		<p>reviewed by</p>   <p>date</p>	

<p>What <b>INCREASES</b> your pain? (check all that apply)</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> sitting</td> <td><input type="checkbox"/> going up or down stairs</td> <td><input type="checkbox"/> driving a vehicle</td> </tr> <tr> <td><input type="checkbox"/> standing</td> <td><input type="checkbox"/> bending or transferring positions</td> <td><input type="checkbox"/> sports, physical recreation, crafts, or hobbies</td> </tr> <tr> <td><input type="checkbox"/> walking</td> <td><input type="checkbox"/> employment or working</td> <td><input type="checkbox"/> self-care (bathing, dressing, toileting, etc.)</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> lifting, carrying, housework, or yard work (laundry, meal preparation, etc.)</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> other, describe: .....</td> </tr> <tr> <td colspan="3">.....</td> </tr> </table>	<input type="checkbox"/> sitting	<input type="checkbox"/> going up or down stairs	<input type="checkbox"/> driving a vehicle	<input type="checkbox"/> standing	<input type="checkbox"/> bending or transferring positions	<input type="checkbox"/> sports, physical recreation, crafts, or hobbies	<input type="checkbox"/> walking	<input type="checkbox"/> employment or working	<input type="checkbox"/> self-care (bathing, dressing, toileting, etc.)	<input type="checkbox"/> lifting, carrying, housework, or yard work (laundry, meal preparation, etc.)			<input type="checkbox"/> other, describe: .....			.....			<p><b>THIS COLUMN FOR OFFICE STAFF USE ONLY. ↓</b></p> <p>HPI (cont'd) CARF</p>															
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<input type="checkbox"/> lifting, carrying, housework, or yard work (laundry, meal preparation, etc.)																																		
<input type="checkbox"/> other, describe: .....																																		
.....																																		
<p>Does your pain keep you from falling asleep at night? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Does your pain awaken you at night? <input type="checkbox"/> yes <input type="checkbox"/> no</p>																																		
<p>What is your goal for treatment at the Pain Center? (For example: What are the activities you would like to do if the pain was better controlled?)</p> <p>.....</p> <p>.....</p>																																		
<p>Do you have any other comments about your pain, not already noted here?</p> <p>.....</p> <p>.....</p>																																		
<p><b>Past Medical History</b> - What are your past or current <u>medical problems</u>? (check all that apply)</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> heart disease</td> <td><input type="checkbox"/> colitis</td> <td><input type="checkbox"/> tumor or cancer</td> </tr> <tr> <td><input type="checkbox"/> rheumatic fever</td> <td><input type="checkbox"/> pancreatitis</td> <td><input type="checkbox"/> neurological disease</td> </tr> <tr> <td><input type="checkbox"/> high blood pressure</td> <td><input type="checkbox"/> bladder or kidney disease</td> <td><input type="checkbox"/> seizures</td> </tr> <tr> <td><input type="checkbox"/> lung disease</td> <td><input type="checkbox"/> arthritis</td> <td><input type="checkbox"/> stroke</td> </tr> <tr> <td><input type="checkbox"/> bronchitis or pneumonia</td> <td><input type="checkbox"/> diabetes</td> <td><input type="checkbox"/> tension headache</td> </tr> <tr> <td><input type="checkbox"/> asthma</td> <td><input type="checkbox"/> thyroid or other endocrine disorder</td> <td><input type="checkbox"/> migraine headache</td> </tr> <tr> <td><input type="checkbox"/> liver or gall bladder problem</td> <td><input type="checkbox"/> anemia or blood disease</td> <td><input type="checkbox"/> drug addiction or alcoholism</td> </tr> <tr> <td><input type="checkbox"/> hepatitis</td> <td><input type="checkbox"/> bleeding disorder</td> <td><input type="checkbox"/> chemical dependency treatment</td> </tr> <tr> <td><input type="checkbox"/> peptic ulcer disease</td> <td><input type="checkbox"/> other medical or pain problems not previously noted, describe:</td> <td><input type="checkbox"/> mental or nervous disorder</td> </tr> <tr> <td colspan="3">.....</td> </tr> <tr> <td colspan="3">.....</td> </tr> </table>	<input type="checkbox"/> heart disease	<input type="checkbox"/> colitis	<input type="checkbox"/> tumor or cancer	<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> pancreatitis	<input type="checkbox"/> neurological disease	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> bladder or kidney disease	<input type="checkbox"/> seizures	<input type="checkbox"/> lung disease	<input type="checkbox"/> arthritis	<input type="checkbox"/> stroke	<input type="checkbox"/> bronchitis or pneumonia	<input type="checkbox"/> diabetes	<input type="checkbox"/> tension headache	<input type="checkbox"/> asthma	<input type="checkbox"/> thyroid or other endocrine disorder	<input type="checkbox"/> migraine headache	<input type="checkbox"/> liver or gall bladder problem	<input type="checkbox"/> anemia or blood disease	<input type="checkbox"/> drug addiction or alcoholism	<input type="checkbox"/> hepatitis	<input type="checkbox"/> bleeding disorder	<input type="checkbox"/> chemical dependency treatment	<input type="checkbox"/> peptic ulcer disease	<input type="checkbox"/> other medical or pain problems not previously noted, describe:	<input type="checkbox"/> mental or nervous disorder	.....			.....			<p>PMH 1/3</p>
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.....																																		
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<p><b>Past Surgical History</b> - List <b>ALL</b> surgery &amp; dates (month/year):</p> <p>.....</p> <p>.....</p>	<p>PSH 1/3</p> <p>meds 2/3</p> <p>allergies 2/3</p> <p>reviewed by</p>																																	
<p>Do you use <b>anticoagulants</b> (such as heparin, coumadin, Fragmin, Lovenox, enoxaparin, Normiflo, ardeparin, Orgaran, danaparoid)? <input type="checkbox"/> yes <input type="checkbox"/> no (If yes, please include all anticoagulants on your medication list on the next page.)</p>	<p>date</p>																																	
<p>Do you use <b>over-the-counter medications</b>? <input type="checkbox"/> yes <input type="checkbox"/> no (If yes, please include all over-the-counter medications on your medication list on the next page.)</p>																																		
<p>Do you use recreational drugs or medications which were prescribed for someone else? <input type="checkbox"/> yes <input type="checkbox"/> no (If yes, please include all these medications on your medication list on the next page.)</p>																																		



This list will be verified & updated every time you visit the Pain Management Center. Please write legibly.

*Medication Reconciliation  
Med Pain Hx 3*

**MEDICATIONS** - Please list all your current prescribed and over-the-counter medications:

COLUMN 1	START YOUR LIST HERE	COLUMN 2	continue your list here from column 1	COLUMN 3	continue your list here from column 2
<i>medication - dose - frequency</i>		<i>medication - dose - frequency</i>		<i>medication - dose - frequency</i>	
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**Allergies or medication problems:** Please list all the medications you are allergic to and/or have had problems tolerating. Briefly list the specific allergy or problem which occurred.

<i>medication - allergy or problem</i>	<i>medication - allergy or problem</i>
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<b>Review of systems - Do you have? Please check <input type="checkbox"/> yes or <input type="checkbox"/> no for each item:</b>			<b>THIS COLUMN FOR OFFICE STAFF USE ONLY. ↓</b> ROS 10/14	
<b>constitutional</b> 1/10 weight loss <input type="checkbox"/> yes <input type="checkbox"/> no fatigue <input type="checkbox"/> yes <input type="checkbox"/> no chills/fever <input type="checkbox"/> yes <input type="checkbox"/> no decreased appetite <input type="checkbox"/> yes <input type="checkbox"/> no <b>eyes</b> 2/10 eye discharge <input type="checkbox"/> yes <input type="checkbox"/> no glasses or contacts <input type="checkbox"/> yes <input type="checkbox"/> no excess tearing <input type="checkbox"/> yes <input type="checkbox"/> no eye pain <input type="checkbox"/> yes <input type="checkbox"/> no vision changes <input type="checkbox"/> yes <input type="checkbox"/> no <b>ENT</b> 3/10 earache <input type="checkbox"/> yes <input type="checkbox"/> no ear discharge <input type="checkbox"/> yes <input type="checkbox"/> no hearing loss <input type="checkbox"/> yes <input type="checkbox"/> no ringing of the ears <input type="checkbox"/> yes <input type="checkbox"/> no ear infection <input type="checkbox"/> yes <input type="checkbox"/> no post-nasal drip <input type="checkbox"/> yes <input type="checkbox"/> no sore throat <input type="checkbox"/> yes <input type="checkbox"/> no bleeding gums <input type="checkbox"/> yes <input type="checkbox"/> no <b>cardiovascular</b> 4/10 chest pain <input type="checkbox"/> yes <input type="checkbox"/> no angina <input type="checkbox"/> yes <input type="checkbox"/> no palpitations <input type="checkbox"/> yes <input type="checkbox"/> no heart murmur <input type="checkbox"/> yes <input type="checkbox"/> no short of breath with activity or at rest <input type="checkbox"/> yes <input type="checkbox"/> no <b>respiratory</b> 5/10 chronic cough <input type="checkbox"/> yes <input type="checkbox"/> no wheezing <input type="checkbox"/> yes <input type="checkbox"/> no short of breath at rest <input type="checkbox"/> yes <input type="checkbox"/> no	<b>gastrointestinal</b> 6/10 heartburn <input type="checkbox"/> yes <input type="checkbox"/> no peptic ulcers <input type="checkbox"/> yes <input type="checkbox"/> no nausea <input type="checkbox"/> yes <input type="checkbox"/> no vomiting <input type="checkbox"/> yes <input type="checkbox"/> no diarrhea <input type="checkbox"/> yes <input type="checkbox"/> no constipation <input type="checkbox"/> yes <input type="checkbox"/> no laxative use <input type="checkbox"/> yes <input type="checkbox"/> no jaundice <input type="checkbox"/> yes <input type="checkbox"/> no loss of bowel control <input type="checkbox"/> yes <input type="checkbox"/> no <b>genitourinary</b> 7/10 frequent urination <input type="checkbox"/> yes <input type="checkbox"/> no urinary tract infections <input type="checkbox"/> yes <input type="checkbox"/> no painful urination <input type="checkbox"/> yes <input type="checkbox"/> no urinary retention <input type="checkbox"/> yes <input type="checkbox"/> no urinary dribbling <input type="checkbox"/> yes <input type="checkbox"/> no loss of urinary control <input type="checkbox"/> yes <input type="checkbox"/> no <b>musculoskeletal</b> 8/10 joint pain <input type="checkbox"/> yes <input type="checkbox"/> no joint swelling <input type="checkbox"/> yes <input type="checkbox"/> no joint stiffness <input type="checkbox"/> yes <input type="checkbox"/> no muscle pain <input type="checkbox"/> yes <input type="checkbox"/> no muscle swelling <input type="checkbox"/> yes <input type="checkbox"/> no <b>neurological</b> 9/10 numbness <input type="checkbox"/> yes <input type="checkbox"/> no tingling <input type="checkbox"/> yes <input type="checkbox"/> no tremor <input type="checkbox"/> yes <input type="checkbox"/> no fainting <input type="checkbox"/> yes <input type="checkbox"/> no headaches <input type="checkbox"/> yes <input type="checkbox"/> no weakness <input type="checkbox"/> yes <input type="checkbox"/> no dizziness <input type="checkbox"/> yes <input type="checkbox"/> no	<b>skin</b> 10/10 skin itching <input type="checkbox"/> yes <input type="checkbox"/> no skin rash <input type="checkbox"/> yes <input type="checkbox"/> no skin infection <input type="checkbox"/> yes <input type="checkbox"/> no <b>endocrine</b> 11/10 hot flashes <input type="checkbox"/> yes <input type="checkbox"/> no hair loss <input type="checkbox"/> yes <input type="checkbox"/> no always hot <input type="checkbox"/> yes <input type="checkbox"/> no always cold <input type="checkbox"/> yes <input type="checkbox"/> no always thirsty <input type="checkbox"/> yes <input type="checkbox"/> no <b>hematologic - lymphatic</b> 12/10 easy bruising <input type="checkbox"/> yes <input type="checkbox"/> no easy bleeding <input type="checkbox"/> yes <input type="checkbox"/> no anemia <input type="checkbox"/> yes <input type="checkbox"/> no swollen nodes <input type="checkbox"/> yes <input type="checkbox"/> no <b>allergic - immunologic</b> 13/10 AIDS <input type="checkbox"/> yes <input type="checkbox"/> no steroid use <input type="checkbox"/> yes <input type="checkbox"/> no frequent infections <input type="checkbox"/> yes <input type="checkbox"/> no allergies <input type="checkbox"/> yes <input type="checkbox"/> no hives <input type="checkbox"/> yes <input type="checkbox"/> no <b>psychiatric</b> 14/10 anxiety <input type="checkbox"/> yes <input type="checkbox"/> no depression <input type="checkbox"/> yes <input type="checkbox"/> no mood swings <input type="checkbox"/> yes <input type="checkbox"/> no nightmares <input type="checkbox"/> yes <input type="checkbox"/> no <b>FOR MEN ONLY</b> Do you have problems with erections? <input type="checkbox"/> yes <input type="checkbox"/> no <b>FOR WOMEN ONLY</b> Could you be pregnant now? <input type="checkbox"/> yes <input type="checkbox"/> no		
If you smoke, how much do you smoke? If you drink beverages with alcohol, how much do you consume? Has anyone complained about your drinking? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, who complained? If you drink beverages with caffeine, how much do you consume?	Is your father alive? <input type="checkbox"/> yes <input type="checkbox"/> no What health problems does your father have? (If deceased, cause of death?) ..... Is your mother alive? <input type="checkbox"/> yes <input type="checkbox"/> no What health problems does your mother have? (If deceased, cause of death?) .....	Marital status: Are you...? <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed Do you have children or other dependents at home? <input type="checkbox"/> yes <input type="checkbox"/> no    If yes, please list children's ages, or describe other dependents: ..... ..... ..... .....		
				PFSH 3/3            reviewed by _____  date _____

<b>Current employer:</b> <hr/> <table style="width:100%; border:none;"> <tr> <td style="width:30%; border:none;">How many years have you worked for this employer?</td> <td style="width:70%; border:none;">Occupation (brief job description or type of work activity):</td> </tr> </table>	How many years have you worked for this employer?	Occupation (brief job description or type of work activity):	<b>THIS COLUMN FOR OFFICE STAFF USE ONLY. ↓</b>												
How many years have you worked for this employer?	Occupation (brief job description or type of work activity):														
<b>Are you working?</b> <input type="checkbox"/> yes <input type="checkbox"/> no <table style="width:100%; border:none;"> <tr> <td style="width:45%; border:none;">If not working, when did you last work?</td> <td style="width:10%; border:none;"></td> <td style="width:40%; border:none;">If not working, is pain preventing you from working?   <input type="checkbox"/> yes   <input type="checkbox"/> no</td> </tr> <tr> <td style="border:none;">If not working, when will your off work slip expire?</td> <td style="border:none;"></td> <td style="border:none;">If not working, would you like to return to work?   <input type="checkbox"/> yes   <input type="checkbox"/> no</td> </tr> <tr> <td colspan="3" style="border:none;">If not working, who took you off work?</td> </tr> </table>	If not working, when did you last work?		If not working, is pain preventing you from working? <input type="checkbox"/> yes <input type="checkbox"/> no	If not working, when will your off work slip expire?		If not working, would you like to return to work? <input type="checkbox"/> yes <input type="checkbox"/> no	If not working, who took you off work?			work 3/3 WC disability litigation					
If not working, when did you last work?		If not working, is pain preventing you from working? <input type="checkbox"/> yes <input type="checkbox"/> no													
If not working, when will your off work slip expire?		If not working, would you like to return to work? <input type="checkbox"/> yes <input type="checkbox"/> no													
If not working, who took you off work?															
<b>Are you on disability?</b> <input type="checkbox"/> yes <input type="checkbox"/> no <table style="width:100%; border:none;"> <tr> <td style="width:35%; border:none;">If yes, when did your disability start?</td> <td style="width:65%; border:none;">If yes, what was the medical diagnosis for your disability?</td> </tr> <tr> <td style="border:none;">If yes, which type of disability do you have? (check all that apply)</td> <td style="border:none;"> <input type="checkbox"/> short term disability      <input type="checkbox"/> other, describe:  <input type="checkbox"/> long term disability  <input type="checkbox"/> social security disability         </td> </tr> </table>	If yes, when did your disability start?	If yes, what was the medical diagnosis for your disability?	If yes, which type of disability do you have? (check all that apply)	<input type="checkbox"/> short term disability <input type="checkbox"/> other, describe: <input type="checkbox"/> long term disability <input type="checkbox"/> social security disability											
If yes, when did your disability start?	If yes, what was the medical diagnosis for your disability?														
If yes, which type of disability do you have? (check all that apply)	<input type="checkbox"/> short term disability <input type="checkbox"/> other, describe: <input type="checkbox"/> long term disability <input type="checkbox"/> social security disability														
<b>Are you on Workers Compensation (WC)?</b> <input type="checkbox"/> yes <input type="checkbox"/> no <table style="width:100%; border:none;"> <tr> <td style="width:45%; border:none;">If yes, when did your WC start?</td> <td style="width:55%; border:none;">Is your WC claim in dispute?      <input type="checkbox"/> yes   <input type="checkbox"/> no</td> </tr> </table>	If yes, when did your WC start?	Is your WC claim in dispute? <input type="checkbox"/> yes <input type="checkbox"/> no													
If yes, when did your WC start?	Is your WC claim in dispute? <input type="checkbox"/> yes <input type="checkbox"/> no														
<b>If you are involved in a lawsuit(s),</b> who is the lawsuit against?   (check all that apply) <input type="checkbox"/> lawsuit regarding a disability claim <input type="checkbox"/> other, describe: <input type="checkbox"/> lawsuit regarding an auto accident <input type="checkbox"/> lawsuit with Workers Compensation															
<b>Diagnostics</b> - What diagnostic studies, such as xrays, CT scans, MRI's, myelograms, EMG's (electromyogram), or bone scans have been done within the last 5 years? List below, including type of study, date completed, which part of the body was studied, and the hospital or office where the study was performed. <i>For example: MRI - 2001 - low back - Sparrow</i> <table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none; border-bottom: 1px solid black;"><i>diagnostic test - date - part of body - where</i></td> <td style="width:50%; border:none; border-bottom: 1px solid black;"><i>diagnostic test - date - part of body - where</i></td> </tr> <tr><td style="border:none;">.....</td><td style="border:none;">.....</td></tr> <tr><td style="border:none;">.....</td><td style="border:none;">.....</td></tr> <tr><td style="border:none;">.....</td><td style="border:none;">.....</td></tr> <tr><td style="border:none;">.....</td><td style="border:none;">.....</td></tr> <tr><td style="border:none;">.....</td><td style="border:none;">.....</td></tr> <tr><td style="border:none;">.....</td><td style="border:none;">.....</td></tr> </table>	<i>diagnostic test - date - part of body - where</i>	<i>diagnostic test - date - part of body - where</i>	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	diagnostics
<i>diagnostic test - date - part of body - where</i>	<i>diagnostic test - date - part of body - where</i>														
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<b>Physicians, psychologists, or healthcare professionals involved in your care</b> - List all physicians and mental health professionals you have consulted (including those for non-pain complaints): <table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none; border-bottom: 1px solid black;"><i>name - date last seen - office phone #</i></td> <td style="width:50%; border:none; border-bottom: 1px solid black;"><i>name - date last seen - office phone #</i></td> </tr> <tr><td style="border:none;">.....</td><td style="border:none;">.....</td></tr> <tr><td style="border:none;">.....</td><td style="border:none;">.....</td></tr> <tr><td style="border:none;">.....</td><td style="border:none;">.....</td></tr> <tr><td style="border:none;">.....</td><td style="border:none;">.....</td></tr> <tr><td style="border:none;">.....</td><td style="border:none;">.....</td></tr> </table>	<i>name - date last seen - office phone #</i>	<i>name - date last seen - office phone #</i>	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	physicians psychologists other providers  reviewed by  date		
<i>name - date last seen - office phone #</i>	<i>name - date last seen - office phone #</i>														
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