Name	Today's date
Date of birth	Primary care physician
Age	Referring physician

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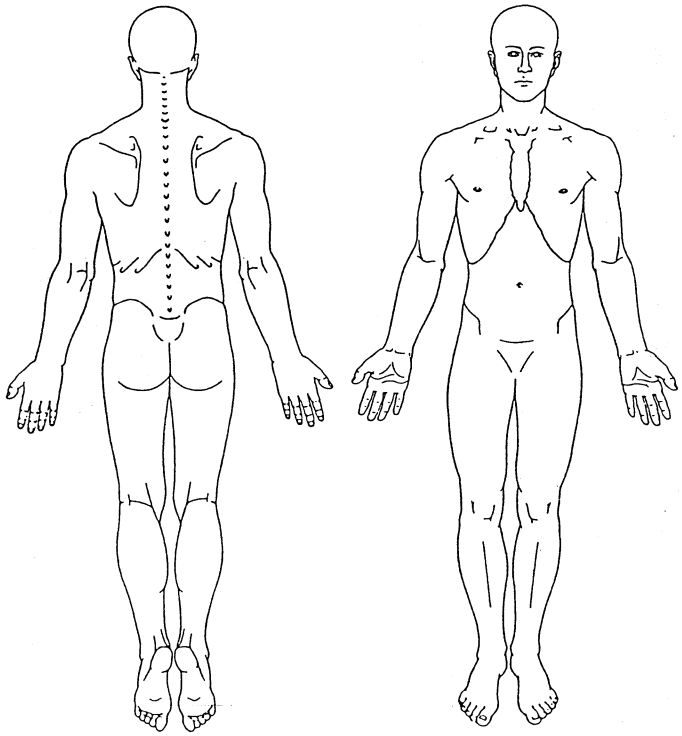
CC & HPI
timing 1/4
duration 2/4
location 3/4
quality 4/4
context 5/4
modifying factors 6/4
severity 7/4
sleep

WHERE is your pain? Color the areas on this diagram where your pain has been for the **last 2-3 weeks**:

RED = Excruciating pain
GREEN = Moderate pain
BLUE = Severe pain
YELLOW = Mild pain



WHEN did your pain start?

In the last 2-3 weeks, **WHEN** does your pain occur?
- ❑ intermittent (on/off)
- ❑ 8-16 hrs/day
- ❑ less than 8 hrs/day
- ❑ constant

HOW did your pain start?
- ❑ auto accident
- ❑ work related
- ❑ after surgery
- ❑ fall (not at work)
- ❑ other, describe:

WHAT does your pain feel like? (check all that apply)
- ❑ burning ❑ mild
- ❑ sharp ❑ moderate
- ❑ dull ❑ severe
- ❑ stabbing ❑ aching
- ❑ cramping
- ❑ other, describe:

What has been used to **TREAT** your pain? (check all that apply)
- ❑ medications ❑ individual psychotherapy ❑ other Pain Center
- ❑ biofeedback ❑ group psychotherapy ❑ physical therapy
- ❑ injections ❑ relaxation training ❑ occupational therapy
- ❑ treatments in emergency room (ER) - how many times have you been to the ER for pain control over the last 3 months? _____
- ❑ other, describe:

What **DECREASES** your pain? (check all that apply)
- ❑ sitting ❑ bending ❑ heat ❑ relaxation exercises ❑ medications
- ❑ standing ❑ lying flat ❑ cold ❑ rest ❑ injections
- ❑ walking ❑ not working ❑ physical therapy
- ❑ other, describe:

reviewed by

date

What **INCREASES** your pain? (check all that apply)

- ❑ sitting
- ❑ standing
- ❑ walking
- ❑ going up or down stairs
- ❑ bending or transferring positions
- ❑ employment or working
- ❑ driving a vehicle
- ❑ sports, physical recreation, crafts, or hobbies
- ❑ self-care (bathing, dressing, toileting, etc.)
- ❑ lifting, carrying, housework, or yard work (laundry, meal preparation, etc.)
- ❑ other, describe: .....

Does your pain keep you from falling asleep at night? ❑ yes ❑ no

Does your pain awaken you at night? ❑ yes ❑ no

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?)

.....

.....

Do you have any other comments about your pain, not already noted here?

.....

.....

Past Medical History - What are your past or current <u>medical problems</u>? (check all that apply)

- ❑ heart disease
- ❑ rheumatic fever
- ❑ high blood pressure
- ❑ lung disease
- ❑ bronchitis or pneumonia
- ❑ asthma
- ❑ liver or gall bladder problem
- ❑ hepatitis
- ❑ peptic ulcer disease
- ❑ colitis
- ❑ pancreatitis
- ❑ bladder or kidney disease
- ❑ arthritis
- ❑ diabetes
- ❑ thyroid or other endocrine disorder
- ❑ anemia or blood disease
- ❑ bleeding disorder
- ❑ tumor or cancer
- ❑ neurological disease
- ❑ seizures
- ❑ stroke
- ❑ tension headache
- ❑ migraine headache
- ❑ drug addiction or alcoholism
- ❑ chemical dependency treatment
- ❑ mental or nervous disorder
- ❑ other medical or pain problems not previously noted, describe:

.....

.....

Past Surgical History - List **ALL** surgery & dates (month/year):

....

....

Do you use **anticoagulants** (such as heparin, coumadin, Fragmin, Lovenox, enoxaparin, Normiflo, ardeparin, Orgaran, danaparoid)? ❑ yes ❑ no
(If yes, please include all anticoagulants on your medication list on the next page.)

Do you use **over-the-counter medications**? ❑ yes ❑ no
(If yes, please include all over-the-counter medications on your medication list on the next page.)

Do you use recreational drugs or medications which were prescribed for someone else? ❑ yes ❑ no
(If yes, please include all these medications on your medication list on the next page.)

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HPI (cont'd)
CARF

PMH 1/3

PSH 1/3

meds 2/3
allergies 2/3

reviewed by

date

PAIN MANAGEMENT CENTER
OF LANSING

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

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**
medication - dose - frequency	*medication - dose - frequency*	*medication - dose - frequency*

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.

medication - allergy or problem	*medication - allergy or problem*

Review of systems - Do you have? Please check ❑ **yes** or ❑ **no** for each item:

constitutional 1/10

weight loss	❑ yes ❑ no
fatigue	❑ yes ❑ no
chills/fever	❑ yes ❑ no
decreased appetite	❑ yes ❑ no

eyes 2/10

eye discharge	❑ yes ❑ no
glasses or contacts	❑ yes ❑ no
excess tearing	❑ yes ❑ no
eye pain	❑ yes ❑ no
vision changes	❑ yes ❑ no

ENT 3/10

earache	❑ yes ❑ no
ear discharge	❑ yes ❑ no
hearing loss	❑ yes ❑ no
ringing of the ears	❑ yes ❑ no
ear infection	❑ yes ❑ no
post-nasal drip	❑ yes ❑ no
sore throat	❑ yes ❑ no
bleeding gums	❑ yes ❑ no

cardiovascular 4/10

chest pain	❑ yes ❑ no
angina	❑ yes ❑ no
palpitations	❑ yes ❑ no
heart murmur	❑ yes ❑ no
short of breath with activity or at rest	❑ yes ❑ no

respiratory 5/10

chronic cough	❑ yes ❑ no
wheezing	❑ yes ❑ no
short of breath at rest	❑ yes ❑ no

gastrointestinal 6/10

heartburn	❑ yes ❑ no
peptic ulcers	❑ yes ❑ no
nausea	❑ yes ❑ no
vomiting	❑ yes ❑ no
diarrhea	❑ yes ❑ no
constipation	❑ yes ❑ no
laxative use	❑ yes ❑ no
jaundice	❑ yes ❑ no
loss of bowel control	❑ yes ❑ no

genitourinary 7/10

frequent urination	❑ yes ❑ no
urinary tract infections	❑ yes ❑ no
painful urination	❑ yes ❑ no
urinary retention	❑ yes ❑ no
urinary dribbling	❑ yes ❑ no
loss of urinary control	❑ yes ❑ no

musculoskeletal 8/10

joint pain	❑ yes ❑ no
joint swelling	❑ yes ❑ no
joint stiffness	❑ yes ❑ no
muscle pain	❑ yes ❑ no
muscle swelling	❑ yes ❑ no

neurological 9/10

numbness	❑ yes ❑ no
tingling	❑ yes ❑ no
tremor	❑ yes ❑ no
fainting	❑ yes ❑ no
headaches	❑ yes ❑ no
weakness	❑ yes ❑ no
dizziness	❑ yes ❑ no

skin 10/10

skin itching	❑ yes ❑ no
skin rash	❑ yes ❑ no
skin infection	❑ yes ❑ no

endocrine 11/10

hot flashes	❑ yes ❑ no
hair loss	❑ yes ❑ no
always hot	❑ yes ❑ no
always cold	❑ yes ❑ no
always thirsty	❑ yes ❑ no

hematologic - lymphatic 12/10

easy bruising	❑ yes ❑ no
easy bleeding	❑ yes ❑ no
anemia	❑ yes ❑ no
swollen nodes	❑ yes ❑ no

allergic - immunologic 13/10

AIDS	❑ yes ❑ no
steroid use	❑ yes ❑ no
frequent infections	❑ yes ❑ no
allergies	❑ yes ❑ no
hives	❑ yes ❑ no

psychiatric 14/10

anxiety	❑ yes ❑ no
depression	❑ yes ❑ no
mood swings	❑ yes ❑ no
nightmares	❑ yes ❑ no

FOR MEN ONLY

Do you have problems with erections? ❑ yes ❑ no

FOR WOMEN ONLY

Could you be pregnant now? ❑ yes ❑ no

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ROS 10/14

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? ❑ yes ❑ no

If yes, who complained?

If you drink beverages with caffeine, how much do you consume?

Is your father alive? ❑ yes ❑ no

What health problems does your father have? (If deceased, cause of death?)

Is your mother alive? ❑ yes ❑ no

What health problems does your mother have? (If deceased, cause of death?)

Marital status: Are you…?

❑ single ❑ married

❑ divorced ❑ widowed

Do you have children or other dependents at home?

❑ yes ❑ no If yes, please list children's ages, or describe other dependents:

PFSH 3/3

reviewed by

date

Current employer:

How many years have you worked for this employer?

Occupation (brief job description or type of work activity):

Are you working? ❑ yes ❑ no

If not working, when did you last work?

If not working, is pain preventing you from working? ❑ yes ❑ no

If not working, when will your off work slip expire?

If not working, would you like to return to work? ❑ yes ❑ no

If not working, who took you off work?

Are you on disability? ❑ yes ❑ no

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)

❑ short term disability
❑ long term disability
❑ social security disability
❑ other, describe: .....

Are you on Workers Compensation (WC)? ❑ yes ❑ no

If yes, when did your WC start?

Is your WC claim in dispute? ❑ yes ❑ no

If you are involved in a lawsuit(s), who is the lawsuit against? (check all that apply)

❑ lawsuit regarding a disability claim
❑ lawsuit regarding an auto accident
❑ lawsuit with Workers Compensation
❑ other, describe: .....

Diagnostics - 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. *For example:* ***MRI - 2001 - low back - Sparrow***

diagnostic test - date - part of body - where	*diagnostic test - date - part of body - where*

Physicians, psychologists, or healthcare professionals involved in your care - List all physicians and mental health professionals you have consulted (including those for non-pain complaints):

name - date last seen - office phone #	*name - date last seen - office phone #*

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work 3/3
WC
disability
litigation

diagnostics

physicians
psychologists
other providers

reviewed by

date