COMPREHENSIVE PAIN MANAGEMENT

NEW PATIENT INFORMATION FORM

Name: ______________________________ **Date:** ____/____/____

HISTORY

Chief Complaint: ______________________________

Where is your pain located? ______________________________

When during the day do you have your pain? ______________________________

What makes your pain worse? ______________________________

What makes your pain better? ______________________________

Describe your pain (circle those that apply): Sharp, Burning, Shooting, Achy, Knife-Like, Twisting, Pressure, Lancinating, Tooth-Ache, Deep, Heavy, gnawing.

How severe is your pain? ____________________
0 (no pain); **1-2** (tolerate without medications); **3-4** (tell someone about my pain, take aspirin or Motrin); **5-6** (mild narcotic, ex. Tylenol#3); **7-8** (go to the ER, take strong narcotics); **9-10** (admission to hospital for pain control).

PAST MEDICAL HISTORY:

Medication ALLERGIES or other allergies? ______________________________

What MEDICATIONS are you presently taking? ______________________________

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MEDICAL ILLNESSES: **Diabetes, Asthma, High Blood Pressure, Heart Attack, Stroke, Cancer, Peptic Ulcers, Rheumatic Fever, Heart Murmur, Mitral Valve Prolapse, HIV/AIDs, Hepatitis, Anemia, Seizures, Gall Bladder, Hyper/Hypo Thyroid,U rinary Tract Infection, Pneumonia, Deep Vein Thrombosis, Bowel Disorder. Other** ______________________________

INJURIES: ______________________________

SURGERIES: ______________________________

HOSPITALIZATIONS: ______________________________

FAMILY HISTORY (parents, siblings, children, grandparents): ______________________________

____

SOCIAL HISTORY:

Marital status: **Married, Single, Divorced, Separated.**

Employment: ______________________________

Education: **Grade School, High School, GED, College, Post Graduate**

IV Drugs: ______________________________

ETOH: Drinks per week? ____________ **TOBACCO: Packs/Day** ______ **Years** ______

ROS:

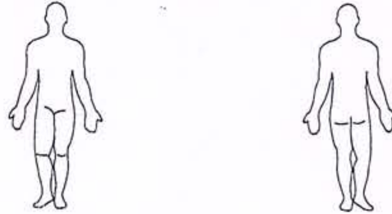
Consitutional = wt change, weakness, fatigue, fever
Eyes = vision, glasses, pain, tearing, double vision
Ears, Nose, Mouth, Throat = hearing, tinnitus, vertigo, pain, sinus, colds, gums, sore throat
Cardiovascular = High blood pressure, rheum fever, murmurs, shortness of breath, chest pain, palpitations
Respiratory = cough, sputum, coughing up blood, wheezing, asthma, bronchitis, chest pain
Gastrointestinal = trouble swallowing, heartburn, vomiting, diarrhea, indigestion, pain, blood, stool changes
Genitourinary = pain with urination, urinating at night, blood in urine, urgency, hesitancy, incontinence

ROS: **Musculoskeletal** = joint pain/stiffness, cramps, back or neck ache, weakness, loss of range of motion
Skin = rash, lumps, itching, dryness, color change, hair changes, nail changes
Neurological = fainting, blackouts, seizures, paralysis, weakness, numbness, memory loss
Psychological = nervousness, tension, mood changes, depression, anxiety
Endocrine = heat or cold intolerance, sweating, thirst, hunger, change in urination
Hematology/Lymphatics = bruising, bleeding, transfusion reactions
Allergies/Immunological = drug, product or other allergies; childhood immunizations

History of IV Drug, Prescription Drug, Illicit Drug Abuse/Addiction?
History of Alcohol Abuse/Addiction?
History of Psychiatric Illness?
History of Suicide Attempt/Ideation?
History of Any Addiction?

On the diagram below, show where you are experiencing pain and/or numbness:

Stabbing //// Numbness ==== Achy AAAA
Burning XXXX Pins & Needles oooo



--DO NOT FILL OUT BELOW THIS LINE--

NEUROLOGICAL EXAMINATION FORM

☐**Vital Signs (3):** BP ____/____ Pulse: ____ RR: ____ Temp: ____ HT/WT: ____/____

System/Body Area	Pertinent Positives & Negatives
Constitutional: ☐ well developed, well nourished, in no acute distress.	
Eyes: ☐ Disc flat, no hemorrhages or exudates noted.	
Cardiovascular: ☐ No Carotid Bruits. ☐ RRR, no murmurs. ☐ No peripheral edema, varicosities, skin warm.	
Musculoskeletal: ☐ Gait coordinated and smooth. ☐ Muscle strength normal (5 out of 5) in both upper and lower extremities. ☐ Muscle tone normal in both upper and lower extremities without spasticity, atrophy, cogwheeling or abnormal movements.	
Neurological: ☐ Alert and oriented x 3. ☐ Recent and remote memory intact. ☐ Concentrates well, not easily distracted. ☐ Speech smooth and clear. ☐ Aware of current events. ☐ CNII = Visual fields full to confrontation; vision intact. ☐ CN III, IV, VI = PERRLA, EOMs intact. ☐ CN V = B/L corneal reflexes and facial sensation intact. ☐ CN VII = Facial movement and strength symmetrical. ☐ CN VIII = B/L hearing with tuning fork equal, whispered voice/finger rub intact. ☐ CN IX = Upward palate movement and pharyngeal muscles contraction, uvula midline. Gag reflex intact. ☐ CN XI = Normal bilateral shoulder shrug strength. ☐ CN XII = Tongue protrusion midline, symmetrical without atrophy, firm pressure. ☐ Bilateral superficial light touch & pain sensation intact. ☐ Deep tendon reflexes in both upper and lower extremities intact and normal. Babinski and Hoffman reflexes negative. ☐ Finger to nose & heel to shin coordination are smooth and accurate.	

NECK
ROM
Spasms
Pain/Palp
Spurling's
TP's
Facets
Post Elements

MIDBACK
ROM
Spasms
Pain/Palp
TP's
Facets
Post Elements

LOW BACK
ROM
Spasms
Pain/Palp
TP's
Facets
Post Elements
SIJ Shear
SIJ PA
PSIS
Patrick's
GT
SLR

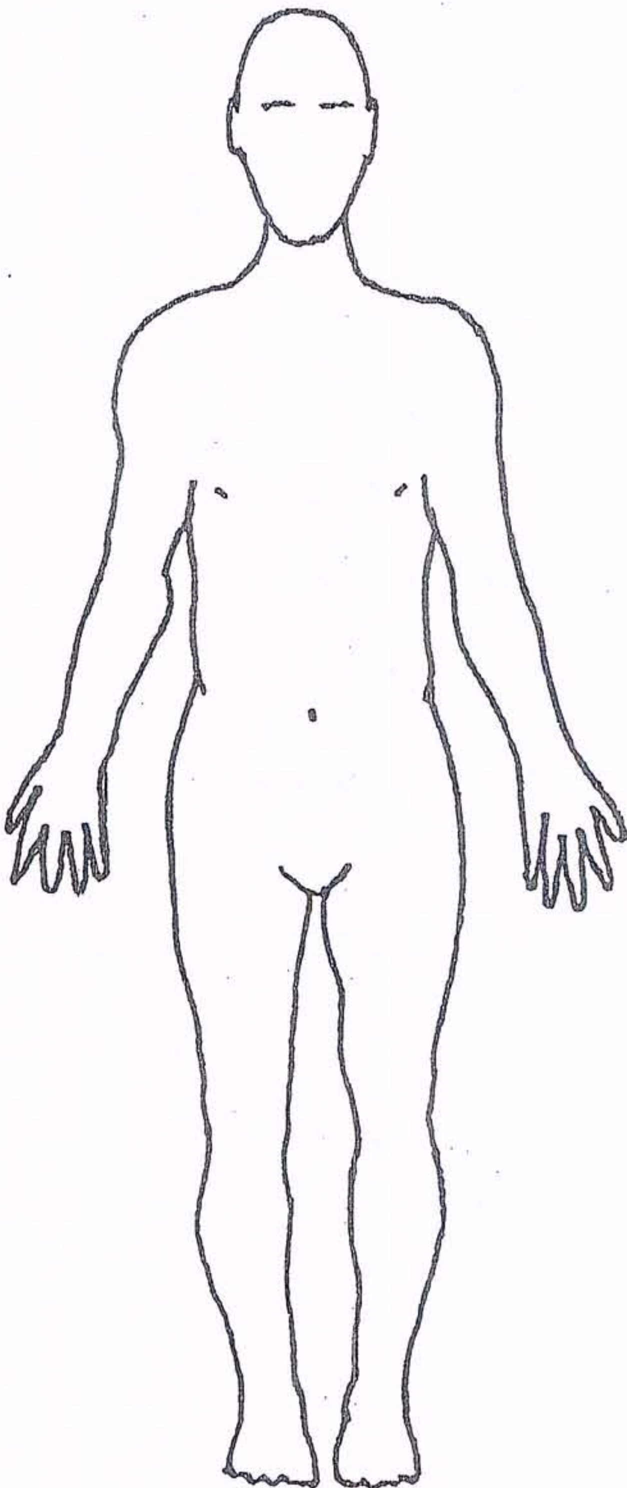
SHOULDER
ROM
Neer's
Hawkin's
GT
Bicep Tendon
Resist AB

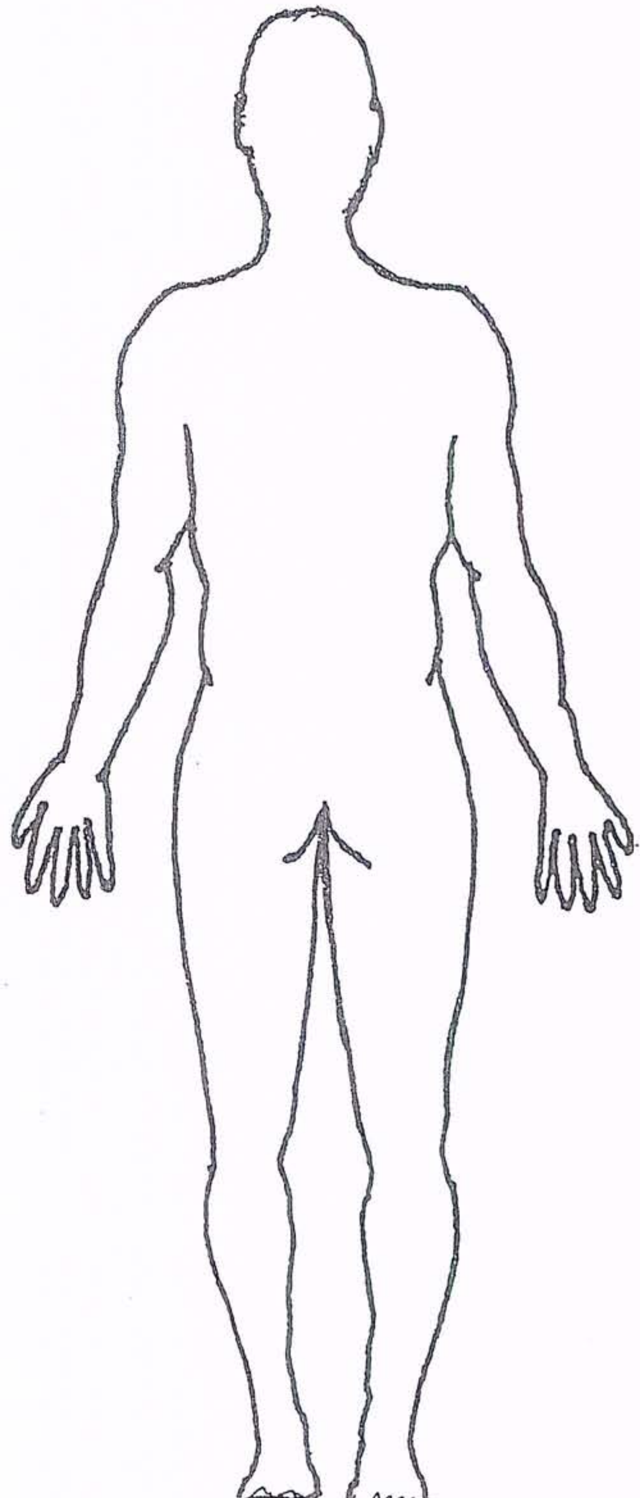
KNEE
ROM
Ant Draw
Lockman
VR/VL
Joint Line
Crepitus
McMurray's
Apply
Patella
TT/Anserine Bursa

Patient Name: ______________________________ Date: ______________

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. You may use more than one symbol. Rate the intensity of all symbols 1-10 with 1 being mild and 10 intolerable.

Numbness xxxxxx	Pins & Needles /////////	Burning ^^^^^^
Ache ————	Other >>>>>>	Stabbing <<<<<<





PAIN

1. Please circle the number that best describes your level of pain right now.

   No pain 0 1 2 3 4 5 6 .7 8 9 10 Worst Pain Imaginable

2. Please circle the number that best describes the average pain you have experienced since your last visit.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

3. Please circle the number that best describes the worst pain you have experienced since your last visit.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

4. Please circle the number that best describes the least pain you have experienced since your last visit.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

5. Please circle the percentage of pain relief that you have obtained since your last visit.

   No relief 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Complete Relief

6. Since last visit, please circle the number of emergency room visits that you have had due to pain.

   0 1 2 3 4 5 or more

7. Since last visit, please mark any reason for which you had to call the Pain Treatment Center.

   ☐ uncontrolled pain ☐ lab/radiology results ☐ medication changes

   ☐ medication side effects ☐ prescription refills

FUNCTION

Since your last visit how much has your pain interfered with the following areas:

8. **Ability to work:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

9. **Ability to sleep:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

10. **Ability to participate in social activities:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

11. **Ability to do household chores:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

12. **Relationship with family:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

13. **Sexual activities:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

14. **General Mood:**

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

15. Do you need to lie down during the day due to pain? o Yes o No

16. If so, please circle how many times on average you need to lie down during the day. 1 2 3 4

17. Do you wake up during the night because of pain? o Yes o No

18. Do you feel rested in the morning? o Yes o No

19. Please circle the average number of hours you sleep at night?

0 1 2 3 4 5 6 7 8 9 10

MEDICATIONS

19. Please mark any medications that you may be on and write in the daily dosage:

o **Oxycontin** o **MS Contin** o **Methadone** o **Fentanyl Patch** o **Oramorph** o **Kadian**

Dosage:____

o **Oxycodone** o **Percocet** o **MSIR**

Dosage ____

Please list any other medications with dosages that you are taking:____________________

____

20. **Please circle the percen..ge of pain relief that you get from your medic.ations.**

No Relief	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	Complete Relief

20. Please mark any bothersome side effects that you may have experienced since your last visit.

o nausea **o constipation** **o itching** **o sleepiness**
o vomiting **o urine problems** **o mood changes** **o inability to concentrate**

21. **Please circle the percentage that best describes how much better your overall pain is since starting at the Pain Treatment Center.**

No Better	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	Completely Better

23 **Please circle the the statement that best describes how satisfied you are with your care at the Pain Treatment Center.**

Not Satisfied Somewhat satisfied Satisfied Very satisfied Completely Satisfied

Additional Comments ____

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Patient Signature ______________________

Thank you for completing this form