

Spectrum Interventional Pain Management

Last Name _____ First Name _____ Age _____

DOB: Month _____ Day _____ Year _____

Sex: Male Female

Insurance Primary _____

Is your pain related to a work-related injury?

Yes No

Insurance Secondary _____

Is your pain related to a motor vehicle accident or other accident?

Yes No

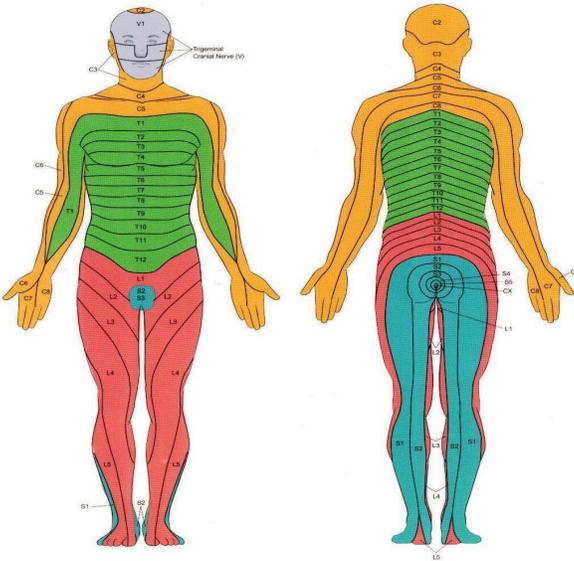
Primary Care Physician _____

Referring Physician _____

History of Present Illness

Location of your pain – Indicate where your pain is:

Describe the location of your worst pain:



Right

Left

Right

How did your pain start?

How long have you experienced this pain?

Have you experienced any other painful conditions before?

Do you feel that your pain is: Getting Better Staying the Same Getting Worse

Describe the *Quality* of your pain (circle all that apply):

Sharp Dull Aching Shooting Electric Throbbing Tingling Numbing Burning
Squeezing Tight Tender Sensitive Itchy Cramping Deep Radiating Heavy
Tearing Stabbing Pounding Piercing Crushing Gnawing Pressure Other

How often do you experience pain? (circle all that apply):

Rarely Occasionally Once per month More than once/month A few days/month
More than a few days/month Most days of the month One day/week Two days/week
Three days/week Four days/week Five days/week All week long All the time

On a scale of 1 to 10, describe the *Severity* of your pain (circle all that apply):

Most of the time - No Pain	1	2	3	4	5	6	7	8	9	10	Worst Pain Ever
On "good days" - No Pain	1	2	3	4	5	6	7	8	9	10	Worst Pain Ever
On "bad days" - No Pain	1	2	3	4	5	6	7	8	9	10	Worst Pain Ever

What time of day is your pain the worst?

Morning Afternoon Evening Night When I'm trying to sleep Pain is always the same

What relieves your pain?

Over the counter medications Prescription medications Narcotic pain medications Topical creams
Exercise Physical Therapy Rest Cool Compress Warm Compress Massage Meditation
Biofeedback Acupuncture TENS unit Back Brace Knee Brace Chiropractic Treatment
Injections Nerve Blocks Epidural Injections Heat Therapy

What makes your pain worse?

Activity Work Lifting Bending Walking Sitting Standing Lying Flat
Driving or riding in a car Rainy days Exercise Housework Other

Does pain sometimes wake you from sleeping? Yes No

How much has your condition decreased your ability to participate in *Physical Activities*?

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

How much has your condition decreased your ability to participate in *Social Activities*?

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

How has your condition affected you *Emotionally*? (circle all that apply):

No Affect Discouraged Depressed Anxious Angry Hopeless Other

Have you seen a psychologist or psychiatrist? Yes No

Have you had "injections" or "nerve blocks" or "epidurals" for your condition before? Yes No

Did the injections help? Yes No

Have you ever had a "bad reaction" to an injection? Yes No If yes, describe:

Have you had Physical Therapy before? Yes No If yes, for how long? When?

Have you had any of the following?

Where was the test performed?

When was the test performed?

MRI scan: Yes No

CT scan: Yes No

X-ray: Yes No

Nerve
Conduction
Study Yes No

Myelogram Yes No

Ultrasound Yes No

Bone Scan Yes No

Other Yes No

Do you have an implanted pacemaker? Yes No

Do you have any implanted orthopedic hardware? Yes No If yes, describe:

Are you taking any *Blood Thinning Medication*? (i.e. Plavix, Coumadin) Yes No

Name of the *Blood Thinning Medication*:

Are you currently or have you ever been involved in a lawsuit because of your condition? Yes No

Are you currently involved in a workers comp case? Yes No

Allergy

List all drug allergies:

List all other allergies:

- | | | |
|--|-----|----|
| Are you allergic to <i>Iodine</i> ? | Yes | No |
| Are you allergic to <i>Latex</i> ? | Yes | No |
| Are you allergic to <i>Contrast Dye</i> ? | Yes | No |
| Are you allergic to <i>Local Anesthetics</i> ? | Yes | No |
| Are you allergic to <i>Steroids</i> ? | Yes | No |

Medications

Please list all the medications you are currently taking for pain:

Have you taken NSAIDs before? Yes No For how long?

List all other current medications:

Have you ever been required to take *Antibiotics* for dental work? Yes No

Do you take blood thinning medication? Yes No

Past Medical History

Please circle all past or present medical conditions:

- | | | |
|--|---|--|
| Allergies
Anemia
Anxiety
Arthritis
Asthma
Blood Clots
Bleeding Disorder
Breast Cancer
Cancer – what type?
Cataracts
CHF
Clotting Disorder
COPD
Depression | Dialysis
Diabetes mellitus
Emphysema
GERD
Glaucoma
Heart Attack or Angina
Heart Murmur
Hepatitis
High Blood Pressure
High Cholesterol
HIV or AIDS
Kidney Disease
Leukemia
Liver Problems | Lung or Breathing Problems
Nerve or Muscle Disease
Osteoporosis
Seizures
Sexually Transmitted Disease
Sickle Cell
Sleep Apnea
Sleep Disorder
Stroke
Thyroid Disease
Tuberculosis
Ulcers
Other: |
|--|---|--|

Please circle all previous surgeries:

- | | | |
|---|--|---|
| Appendectomy
Brain Surgery
Gallbladder Surgery
Colon Surgery
C-section
Eye Surgery
Fracture Surgery
Cosmetic Surgery | Heart Surgery
Hernia Surgery
Spine Surgery - Neck
Spine Surgery – Low Back
Spine Surgery – Mid Back
Hysterectomy
Joint Replacement | Prostate Surgery
Valve Replacement
Breast Surgery
Heart Catheter Procedure
Laparotomy
Thyroid Surgery
Peripheral Bypass
Other: |
|---|--|---|

Family History

Please circle all that apply to your family:

- | | | | |
|--|--|---|--------|
| Bleeding Disorder
Heart Disease
Heart Attack
Kidney Disease
Stroke | Seizures
Scoliosis
Hepatitis
Lung Disease
Cancer | Back Problems
Back Surgery
Rheumatoid Arthritis
Asthma
Degenerative Disc Dz | Other: |
|--|--|---|--------|

Social History

Marital Status: Married Engaged Single Separated Divorced Widowed Partnered

Occupation:	Are you retired?	Yes	No
Education:	Are you on disability?	Yes	No

						For how long?	
Hobbies/Sports/Activities:		Golf	Tennis	Swimming	Jogging	Walking	Regular Exercise
Other:							

Do you have children?	Yes	No	If yes, how many?	Ages:
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Do you smoke cigarettes	Yes	No	How many packs per day?	Would you like to quit?	Yes	No
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Do you drink alcohol?	Yes	No	How many drinks per week?
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Do you use recreational drugs?	Yes	No	Have you ever used IV drugs?	Yes	No
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What are your goals for the treatment of your pain?

Review of Systems

Please circle any of the following symptoms that you have experienced **RECENTLY**:

General Recent Fever Recent Fatigue Night Sweats Weight Loss Weight Gain	Respiratory Shortness of Breath Chronic Cough Wheezing Asthma	Skin Rash Skin Infection Skin Cancer Recent Sores	Blood/Lymph Easy Bruising Use of Blood Thinner Easy Bleeding Swollen Glands Anemia
Eyes Red Eyes Blurry Vision Glaucoma Vision Loss	Gastrointestinal Nausea Vomiting Diarrhea Abdominal Pain	Endocrine Excessive Thirst Excessive Sweating Appetite Change	Allergy Runny Nose Sinus Congestion Itchy Eyes Drug Reaction
Ear Nose Throat Nose Bleeds Sore Throat Hearing Loss Dental Problems	Genitourinary Urinary Tract Infections Burning with Urination Blood in Urine Urinary Incontinence	Nervous System Headache Seizures Memory Loss Weakness Numbness/Tingling	
Cardiovascular Chest Pain Heart Murmur Leg Swelling Stroke Heart Attack	Musculoskeletal Joint Pain Arthritis Gout Muscle Pain	Psychiatric Anxiety Depression Alcohol Abuse Drug Abuse Thoughts of Suicide Panic Attacks	

Patient Signature _____ Date _____

Reviewed by Physician _____ Date _____

