

*Advanced Pain Management Specialists, L LC*  
*Making Life's Journey Pain Free*

Name: \_\_\_\_\_

Visit Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS# : \_\_\_\_\_

Please fill in the questions below as concisely and accurately as possible.  
(A Continuation Sheet is included if required)

The form may seem lengthy but it is very important to help us understand your pain complaints.

This will help us provide you with the highest level of care.

What is your age: \_\_\_\_\_ years

	Doctors Name	Doctors Address
Who is your:		
Primary Care Doctor:	_____	
Referring Doctor:	_____	

Please list any other Pain Specialist you have seen.

Pain Management Specialist: \_\_\_\_\_  
Pain Management Specialist: \_\_\_\_\_

Are there any claims pending that relate to your pain?

- No
- Yes  If yes: Workers compensation
- Social Security disability
- Motor Vehicle Accident
- Other  Please explain \_\_\_\_\_

Do you have more than one area of pain?

- No  Please go to next question
- Yes  Please list the different areas you have pain.  
Please circle the main pain complaint that has brought you here today

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please detail your main pain complaint only in the next section

How long ago did your pain begin: \_\_\_\_\_ weeks/months/years

Describe the events leading up to your present pain complaints:

(Please include all accidents relating to your pain (work, motor vehicle, home, boating etc) and any surgeries related to your pain).

Describe your current pain

Where is it?

Does it radiate anywhere?

(examples: into your arms, legs, chest, abdomen)

Circle the words which best describe your pain?

Circle no more than three

- |           |          |            |
|-----------|----------|------------|
| Aching    | Sharp    | Gnawing    |
| Throbbing | Shooting | Cramping   |
| Tightness | Stabbing | Tearing    |
| Deep      | Searing  | Other..... |

Is the pain intermittent  or constant

Circle the number between 0 -10 that represents the intensity of your pain

- KEY            0 = No Pain  
                  5 = Pain interferes with your ability to function  
                  10 = Pain worst imaginable

Your Average Pain = 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10.

Your Worst Pain = 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10.

What makes your pain feel better?

What makes your pain feel worse?

**What medications have you tried?**

<b>Medication</b>	<b>Still using</b>	<b>Stopped because</b>
<b>Ibuprofen (Motrin/Advil)</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Naprosyn (Alleve)</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Asprin</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Toradol (Ketorolac)</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Arthrotec</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Mobic</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Celebrex</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Vioxx</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Bextra</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Valium</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Flexeril</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Xanaflex</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Somma</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Neurontin</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Tegretol</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Depokote</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Topomax</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Lamictal</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Amitryptiline (Elavil)</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Nortriptyline (Pamelor)</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Effexor</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Lexapro</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Paxil</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Serazone</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Zoloft</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Lidoderm Patches</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Ultram</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Ultracet</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Codeine</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Darvon</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Darvocet N50, N100</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Darvocet A500</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Tylenol #2, 3, or 4</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Percocet 2.5 / 5 / 7.5 / 10</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Lortab 5 / 7.5 / 10</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Percodan</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Methadone</b>	<input type="checkbox"/>	<input type="checkbox"/> _____
<b>Morphine</b>	<input type="checkbox"/>	<input type="checkbox"/> _____

*(Including MSIR, MS Contin, Kadian, Avinza)*

Name _____	Date of Birth _____
<b>Duragesic Patches</b>	<input type="checkbox"/> _____
<b>Actiq Lollipops</b>	<input type="checkbox"/> _____
<b>Oxycodone</b>	<input type="checkbox"/> _____
<b>Oxycontin</b>	<input type="checkbox"/> _____
<b>Dilaudid (Hydromorphone)</b>	<input type="checkbox"/> _____

**Other Pain Medications Tried**

**Please List**

1. _____	<input type="checkbox"/>	<input type="checkbox"/> _____
2. _____	<input type="checkbox"/>	<input type="checkbox"/> _____
3. _____	<input type="checkbox"/>	<input type="checkbox"/> _____
4. _____	<input type="checkbox"/>	<input type="checkbox"/> _____

**What Procedures have you tried?**

Procedure	How Long Ago	Doctor
<b>Trigger Point Injections</b>	_____	_____
<b>Epidural Steroids</b>	_____	_____
<b>Facet Blocks</b>	_____	_____
<b>Sacro-iliac joint injections</b>	_____	_____
<b>Nerve/ Nerve Root Blocks</b>	_____	_____
<b>Spinal Cord Stimulator</b>	_____	_____
<b>Intrathecal Pumps</b>	_____	_____
<b>Other</b>	_____	_____

**What other treatments have you tried?**

	How Long Ago	Where
<b>Physical Therapy</b>	_____	_____
<b>Chiropractor</b>	_____	_____
<b>Aquatherapy</b>	_____	_____
<b>Accupuncture</b>	_____	_____
<b>TENS</b>	_____	_____
<b>Other</b>	_____	_____

**What Surgeries have you had?**

**(Please place in date order. Include surgeries mentioned earlier)**

Surgery	Date	Doctor	Hospital
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____

**What medical problems do you have?**  
(Include any diagnosis of anxiety or depression)

Medical Problem	Treating Doctor	Address
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

**What medications are you currently taking?**

Drug	Dose	Frequency
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____
15. _____	_____	_____

**List all medication allergies**

**Are you allergic to iodine or x-ray contrast?**

No

Yes  Reaction \_\_\_\_\_

Drug	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

**Please Tell use any medical problems affecting your relatives**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Mother**      Alive  List major illnesses \_\_\_\_\_  
Dead  Age and cause of death \_\_\_\_\_

**Father**      Alive  List major illnesses \_\_\_\_\_  
Dead  Age and cause of death \_\_\_\_\_

**Brothers and Sisters**

List illnesses your siblings are suffering from

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are You?**      Single       Married       Divorced       Widowed

**Do you have any children?**

No

Yes  Please list below

	Son/Daughter	Age	Medical Problems
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

**Are you employed?**

No  If No:

Are you:

Disability  Retired  Other  \_\_\_\_\_

What was your job: \_\_\_\_\_

Yes  If yes:

How many hours do you work a week \_\_\_\_\_

What is your job \_\_\_\_\_

**List Your Hobbies and interests?**

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_

**Does your pain stop you doing the things you enjoy?**      No       Yes

**Do you smoke?**      No       Yes  If yes, how much \_\_\_\_\_

Do you drink alcohol? No  Yes  If yes, how much \_\_\_\_\_

Do you use any illegal drugs? No  Yes  If yes, what drugs \_\_\_\_\_

Do you have any of the following symptoms?

**General/Constitutional**

Fever No  Yes  If yes, explain \_\_\_\_\_

Chills No  Yes  If yes, explain \_\_\_\_\_

Fatigue No  Yes  If yes, explain \_\_\_\_\_

**Skin/Allergy**

Rash No  Yes  If yes, explain \_\_\_\_\_

Itching No  Yes  If yes, explain \_\_\_\_\_

Sweating No  Yes  If yes, explain \_\_\_\_\_

**Musculoskeletal**

Joint stiffness No  Yes  If yes, explain \_\_\_\_\_

Joint/bone pain No  Yes  If yes, explain \_\_\_\_\_

Joint swelling No  Yes  If yes, explain \_\_\_\_\_

Muscle cramps No  Yes  If yes, explain \_\_\_\_\_

**Head**

Headaches No  Yes  If yes, explain \_\_\_\_\_

Dizziness No  Yes  If yes, explain \_\_\_\_\_

Fainting No  Yes  If yes, explain \_\_\_\_\_

Sensitivity to light No  Yes  If yes, explain \_\_\_\_\_

Sinus congestion No  Yes  If yes, explain \_\_\_\_\_

Nose bleeds No  Yes  If yes, explain \_\_\_\_\_

Bleeding gums No  Yes  If yes, explain \_\_\_\_\_

Mouth ulcers No  Yes  If yes, explain \_\_\_\_\_

**Endocrine**

Neck Swelling No  Yes  If yes, explain \_\_\_\_\_

Heat/Cold intolerance No  Yes  If yes, explain \_\_\_\_\_

Weight loss/gain No  Yes  If yes, explain \_\_\_\_\_

Appetite change No  Yes  If yes, explain \_\_\_\_\_

Male

Erectile problem No  Yes  If yes, explain \_\_\_\_\_

Female

Abnormal No  Yes  If yes, explain \_\_\_\_\_

Bleeding/Discharge

Pain

**Respiratory**

Wheezing

Cough

Short of Breath No  Yes  If yes, explain \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Cardiovascular**

**Chest pain**

**Palpitations**      No       Yes       If yes, explain \_\_\_\_\_

**Leg swelling**      No       Yes       If yes, explain \_\_\_\_\_

**Hematologic**

**Easy bruising**      No       Yes       If yes, explain \_\_\_\_\_

**Easy Bleeding**      No       Yes       If yes, explain \_\_\_\_\_

**Abnormal clotting**      No       Yes       If yes, explain \_\_\_\_\_

**Lymph Nodes**

**Enargement**      No       Yes       If yes, explain \_\_\_\_\_

**Tenderness**      No       Yes       If yes, explain \_\_\_\_\_

**Gastrointestinal**

**Difficult Swallowing**      No       Yes       If yes, explain \_\_\_\_\_

**Heartburn**      No       Yes       If yes, explain \_\_\_\_\_

**Constipation**      No       Yes       If yes, explain \_\_\_\_\_

**Diarrhea**      No       Yes       If yes, explain \_\_\_\_\_

**Change in stool**      No       Yes       If yes, explain \_\_\_\_\_

**Genitourinary**

**Painful urination**      No       Yes       If yes, explain \_\_\_\_\_

**Difficult urination**      No       Yes       If yes, explain \_\_\_\_\_

**Urgency/frequency**      No       Yes       If yes, explain \_\_\_\_\_

**Incontinence**      No       Yes       If yes, explain \_\_\_\_\_

**Blood in urine**      No       Yes       If yes, explain \_\_\_\_\_

**Neurological**

**Fainting**      No       Yes       If yes, explain \_\_\_\_\_

**Weakness/paralysis**      No       Yes       If yes, explain \_\_\_\_\_

**Tremors**      No       Yes       If yes, explain \_\_\_\_\_

**Headaches**      No       Yes       If yes, explain \_\_\_\_\_

**Migraines**      No       Yes       If yes, explain \_\_\_\_\_

**Psychiatric**

**Depression**      No       Yes       If yes, explain \_\_\_\_\_

**Suicidal thoughts**      No       Yes       If yes, explain \_\_\_\_\_

**Anxiety**      No       Yes       If yes, explain \_\_\_\_\_

**Sleep disturbance**      No       Yes       If yes, explain \_\_\_\_\_

**Patient signature** \_\_\_\_\_

**Person Filling in form if different from patient** \_\_\_\_\_

**Relationship** \_\_\_\_\_

***Advanced Pain Management Specialists, L LC***  
*Making Life's Journey Pain Free*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Continuation Sheet**

**Name:** \_\_\_\_\_

**Visit Date:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Concisely add important information that would not fit into the Patient Information Form**

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Name \_\_\_\_\_ Date of Birth \_\_\_\_\_