Advanced Pain Centers, S.C.

Pre-Visit Questionnaire (PAIN)

Full Name: _____ D.O.B. _____ Date: _____

Date of Service: _____ Height: _____ Weight: _____

I. Chief Complaint (Describe why you are here): _____

_____

_____

II. History of Present Illness: VAS Pain Scale 0 1 2 3 4 5 6 7 8 9 10
No Pain Max Pain

1. When did the pain start: Date: _____ Unknown ☐
2. What caused the pain to start?
   ☐ Car Accident ☐ Accident at work ☐ Unknown ☐ Other_____
3. Describe the pain and specific location(s) (radiating, burning, stabbing, aching, etc.)
   _____
   _____
   _____
   _____
4. What activities increase your pain? (standing, sitting, walking, bending, lifting, etc.)
   _____
   _____
   _____
   _____
5. What decreases your pain? (heat, ice, lying down (position), stretching, exercise, etc.)
   _____
   _____
   _____
   _____
6. Is this a result of motor-vehicle or personal injury? ☐ Yes ☐ No
   If yes, please explain the nature of the injury or accident (were you driver/passenger, restrained or not, speed of vehicle at time of accident):
   _____
   _____
   _____
   _____
   _____
   _____

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7. If workers compensation, please provide details of what happened:

_____
_____
_____

Have you had a Functional Capacity Evaluation? ☐ Yes ☐No If yes, when? _____
Are you currently on any work restrictions? ☐ Yes ☐No
If yes, what are they and which physician placed you on them?

_____
_____
_____

8. Sleep History:
   a. What time do you go to bed? _____
   b. How many hours does it take you to fall asleep? _____
   c. How many times do you wake up at night, and why? _____
   d. How many hours of sleep do you get per night? _____
   e. How many hours of sleep do you require to feel rested? _____
   f. Have you taken sleep medications or natural supplements to help you fall asleep?
      ☐ Yes ☐No If yes, please list: _____
   g. Do you use alcohol to go to sleep? ☐ Yes ☐No

9. Functional History (Please check all that apply):
   Do you require assistance: ☐Driving ☐Walking ☐Standing ☐Stairs ☐Lifting
   ☐Cooking ☐Bathing ☐Toilet ☐Dressing ☐Shopping ☐Ambulating
   ☐Household chores (laundry, dishes, vacuuming, etc)
   ☐Outdoor yard work (mowing grass, trimming, raking, gardening)

   Other treatment for your pain:
   Please list all physicians, chiropractors, massage, therapists, and emergency room physicians you have seen for your problem (use other side if necessary)

   _____
   _____
   _____

10. Who is your primary care/general doctor? When were they last seen?
    Name: _____ Phone: _____ Last seen: _____

11. Other providers seen:

Name	Specialty	Treatment Provided	Did it help
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. Could you be pregnant? ☐Yes ☐No

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III. Past History

1. Allergies: ☐No Know Allergies

☐Latex ☐IVP Dye ☐Iodine ☐Shellfish ☐Sulfa ☐Penicillin

☐Other (please list): _____

_____

2. Medications:

Please list all medications you are currently taking (prescription and non- prescription, including aspirin, Tylenol, fish oil, etc.) Use reverse if more space needed.

Medication (Not For Pain)	Dose	Frequency	Date Started	Prescribing Doctor

Medication (For Pain)	Dose	Frequency	Date Started	Prescribing Doctor

3. Previous Medications/Natural Supplements (Not for pain)

	Effective?
_____	☐Yes ☐No
_____	☐Yes ☐No
_____	☐Yes ☐No
_____	☐Yes ☐No
_____	☐Yes ☐No
_____	☐Yes ☐No

4. Previous Pain Medications/Natural Supplements (For pain)

	Effective?
_____	☐Yes ☐No
_____	☐Yes ☐No
_____	☐Yes ☐No
_____	☐Yes ☐No
_____	☐Yes ☐No

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5. Previous Hospitalizations without surgery ☐Yes ☐No
(include year and physician's name)

_____
_____
_____

6. Past Surgical History ☐Yes ☐No (include year and physician's name)

_____
_____
_____

7. Please list all procedures you have had for pain (Include year and physician's name)

☐Chiropractor _____ When was last visit? _____
☐Physical Therapy Times Per Week _____ When was last visit? _____
☐Massage Times per week _____ When was last visit? _____

8. Interventional Procedures (Epidural injections, Facet injections, etc.)

Procedure	Relief	For How Long
_____	☐Yes ☐No	_____
_____	☐Yes ☐No	_____
_____	☐Yes ☐No	_____
_____	☐Yes ☐No	_____
_____	☐Yes ☐No	_____

IV. Other History Questions:

1. Family Medical History ☐No Problems
(Answers should be mom, dad, brother, sister, aunt, uncle, etc.)

☐Arthritis _____ ☐High Blood Pressure _____ ☐ HIV _____
☐Fibromyalgia _____ ☐Heart Attack _____ ☐ Cancer:
☐Lupus _____ ☐Heart Disease _____ Location _____
☐Multiple Sclerosis _____ ☐Diabetes _____ Relationship _____
☐Epilepsy _____ ☐Bronchial Asthma _____ Location _____
☐Depression _____ ☐Bleeding Disorder _____ Relationship _____
☐Schizophrenia _____ ☐Hepatitis _____ Location _____
☐Alcoholism _____ ☐Thyroid Disorders _____ Relationship _____
☐Addictive Behavior _____ ☐Rehab Center _____ Location _____
☐Suicidal Ideation _____ ☐Suicide Attempt _____ Relationship _____

2. Social History

A. Smoking:

Do you smoke now? ☐Yes ☐No If yes, when did you start? _____
☐Cigarettes # per day? _____
☐Cigars # per day? _____
☐Pipe # per day? _____
Have you ever? ☐Yes ☐No Explain _____

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B. Alcohol:

Do you drink alcohol? ☐Yes ☐No How much? _____

Have you ever had a problem with alcohol? ☐Yes ☐No ☐Cirrhosis of Liver

Explain? _____

_____

C. Caffeinated Drinks:

Do you consume drinks with caffeine? ☐Yes ☐No

☐ Coffee ☐ Tea ☐ Iced Tea ☐ Colas

D. Illicit Drugs:

Do you use any street drugs? ☐Yes ☐No Explain _____

Do you use marijuana? ☐Yes ☐No

E. Marital Status:

☐Married ☐Single ☐Divorced ☐Widowed No. of children: _____

F. Criminal History:

Have you ever been convicted of a crime? ☐Yes ☐No

If yes, what was the nature of the offense leading to conviction?

_____

_____

How recent was such offense? _____

G. Work History:

1. Currently at work: ☐Employed ☐Full-Time ☐Part-Time ☐Self-Employed

Occupation:_____ What shift do you work:_____

How many hours/day?_____ How many hours/week? _____

Describe job duties: _____

Hours you spend standing: _____ sitting: _____ walking: _____

bending: _____ computer work: _____

Do you lift? ☐Yes ☐No How much weight? _____ Repetitions per day? _____

2. Currently not at work: ☐Unemployed ☐Retired ☐Disability

☐Other Specify: _____

3. Litigation History:

☐Open Case ☐Work-Related ☐Personal Injury

Claim #: _____ Date of injury: _____

Name of adjuster/case manager: _____

☐Work with attorney

Name of attorney: _____

Firm Name: _____

Address: _____

_____

Telephone: _____

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V. Review of Systems:

1. Constitutional Symptoms:

☐Weight Loss _____ lbs during _____
☐Weight Gain _____ lbs during _____
☐Trying to lose weight ☐Recurrent Fever
☐General Weakness ☐Fatigue ☐Chills ☐Insomnia
☐Hypersomnolence (over sleeping)

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2. Neurological ☐No Problems

☐Incontinence of urine or stool ☐Frequent or Recurrent Headaches ☐Fainting
☐Blackouts ☐Stroke ☐Gait Difficulties ☐Paralysis ☐Frequent Falls
☐Tremors ☐Neuropathy ☐Weakness ☐Seizures ☐Epilepsy ☐Polio
☐Dizzy Spells ☐Vertigo ☐Problems with concentration ☐Lupus ☐Alzheimer's
☐Problems with thinking or thought process ☐Pain with light touch to skin
☐Problems with memory ☐Confusion ☐Multiple Sclerosis

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3. Hematologic ☐No Problems

☐Blood Transfusion ☐Bleeding Disorder (Hemophilia)
☐Anemia (Iron deficiency, Pernicious, Sickel cell) ☐Easy Bruising
☐IV Drug Use ☐Enlarged Lymph Nodes

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4. Infectious Disease ☐No Problems

☐Hepatitis ☐Type A ☐Type B ☐Type C
☐HIV ☐Herpes ☐Shingles ☐TB (Tuberculosis)

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5. Psychiatric ☐No Problems

☐Suicidal Thoughts ☐Suicide Attempt If yes, when was last attempt? _____
☐Schizophrenia ☐Alcohol/Drug Abuse ☐Crying Spells ☐Mood Swings
☐Suicide attempt requiring hospitalization ☐Depressed ☐Anxious ☐Shaky
☐Agitated ☐Obsessive Compulsive Disorder ☐Nervousness
☐Post Traumatic Stress Disorder ☐Sexual Abuse History ☐Domestic Violence
☐Panic Episode ☐Paranoia ☐Hallucinations
☐Admission to detox center (if yes, what for?) ☐Alcohol ☐Opioids ☐Other
Specify _____
Have you had any previous hospitalizations for psychiatric care or treatment
☐Yes ☐No Specify _____
History of substance abuse or rehab ☐Yes ☐ No

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6. NSAIDS/Anti-Inflammatory ☐None

List name, frequency, dosage (i.e. advil, Ibuprofen, Celebrex, etc.)

_____
_____
_____
_____
_____

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7. Blood Thinners ☐None

List name, frequency, dosage (i.e. Coumadin, Aspirin, Excedrin, Vitamin E, Plavix, Xeralto, garlic, fish oil, etc.)

_____

_____

_____

_____

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8. Musculoskeletal ☐No Problems

☐Muscle Cramps ☐Stiff Joints _____

☐Swelling of Joints ☐Generalized Arthritis ☐Rheumatoid Arthritis

☐Fibromyalgia Syndrome ☐Osteoporosis ☐Neck Pain ☐Upper Back Pain

☐Middle Back Pain ☐Lower Back Pain ☐Heel Spur(s) # _____

☐Joint Pain ☐Hardware ☐Deformity ☐Limited Range of Motion

☐Abnormal sound when moving joint ☐Gout ☐Difficulty with walking

☐Pain in feet ☐Pain with light touch of skin Specify _____

☐Cold Upper Extremity(ies) ☐R ☐L

☐Cold Lower Extremity(ies) ☐R ☐L

☐Painful light touch to skin ☐Post surgical pain

☐Other, specify _____

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9. Cardiac ☐No Problems

☐Heart Trouble ☐Swelling of Feet ☐High Blood Pressure ☐Chest Pain

☐Heart Murmur ☐Heart Failure ☐Stents ☐Shortness of breath with walking

☐Arterial Graft ☐Pacemaker ☐Heart Disease ☐Edema ☐Palpitations

☐PND (Paroxysmal Nocturnal Dyspnea) ☐Blue Extremities ☐Rheumatic Fever

☐Heart Attack or other Cardiac Condition Specify _____

10. Peripheral-Vascular ☐No Problems

☐Thrombophlebitis (Inflamed Veins)

☐Poor circulation in arms ☐R ☐L

☐Blood clots in arms ☐R ☐L

☐Varicose Veins ☐R ☐L

☐Poor circulation in legs ☐R ☐L

☐Blood clots in legs ☐R ☐L

☐Vascular Surgery ☐R ☐L

☐Other _____

_____

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11. Gastrointestinal ☐No Problems

☐IBS (Irritable Bowel Syndrome) ☐Crohn's/Ulcerative Cholitis ☐Constipation

☐Diarrhea ☐Chronic use of laxatives ☐Jaundice (Yellow Eyes)

☐Eating Disorder (Anorexia, Bulemia, etc) ☐Heartburn ☐Melena (Dark Stool)

☐Frequent Bowel Movements ☐Change in Bowel Habits ☐Clay Color Stool

☐Hemorrhoids ☐Rectal Discharge

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12. Endocrine ☐No Problems
☐Diabetes If yes, do you take insulin ☐Yes ☐No
☐Hot/Cold Tolerance ☐Excessive Sweating ☐Polydipsia (Increased Thirst)
☐Polyphagia (Increased Hunger) ☐Infertility ☐Thyroid Disorder

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13. Respiratory ☐No Problems
☐Cough ☐Sputum ☐Hemoptysis (Coughing up blood) ☐Wheezing
☐Asthma ☐Emphysema ☐Bronchitis ☐Pneumonia ☐Pleurisy ☐Sleep Apnea
☐CPAP at night ☐COPD ☐Self-Employed

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14. Other ☐No Problems
☐Cancer Specify _____
☐Rashes/Scars _____

Previous Tests

Which of the following tests have been performed? Mark only applicable tests and dates if known

☐Regular X-Rays of _____
☐CT Scan of _____
☐Myelogram of _____
☐MRI of _____
☐Discogram of _____
☐Bone Scan of _____
☐Nerve Conduction of _____
☐EMG of _____
☐Other, specify _____
_____
_____

Treatment Goal(s):

_____
_____

Certification:

I certify that I have answered truthfully all the questions, and have not knowingly withheld any information concerning any of the above problems, either past or resent.

Patient Signature: _____ Date: _____

Parent Signature if Minor: _____

Transcriber: _____

Reviewing Provider(s): _____

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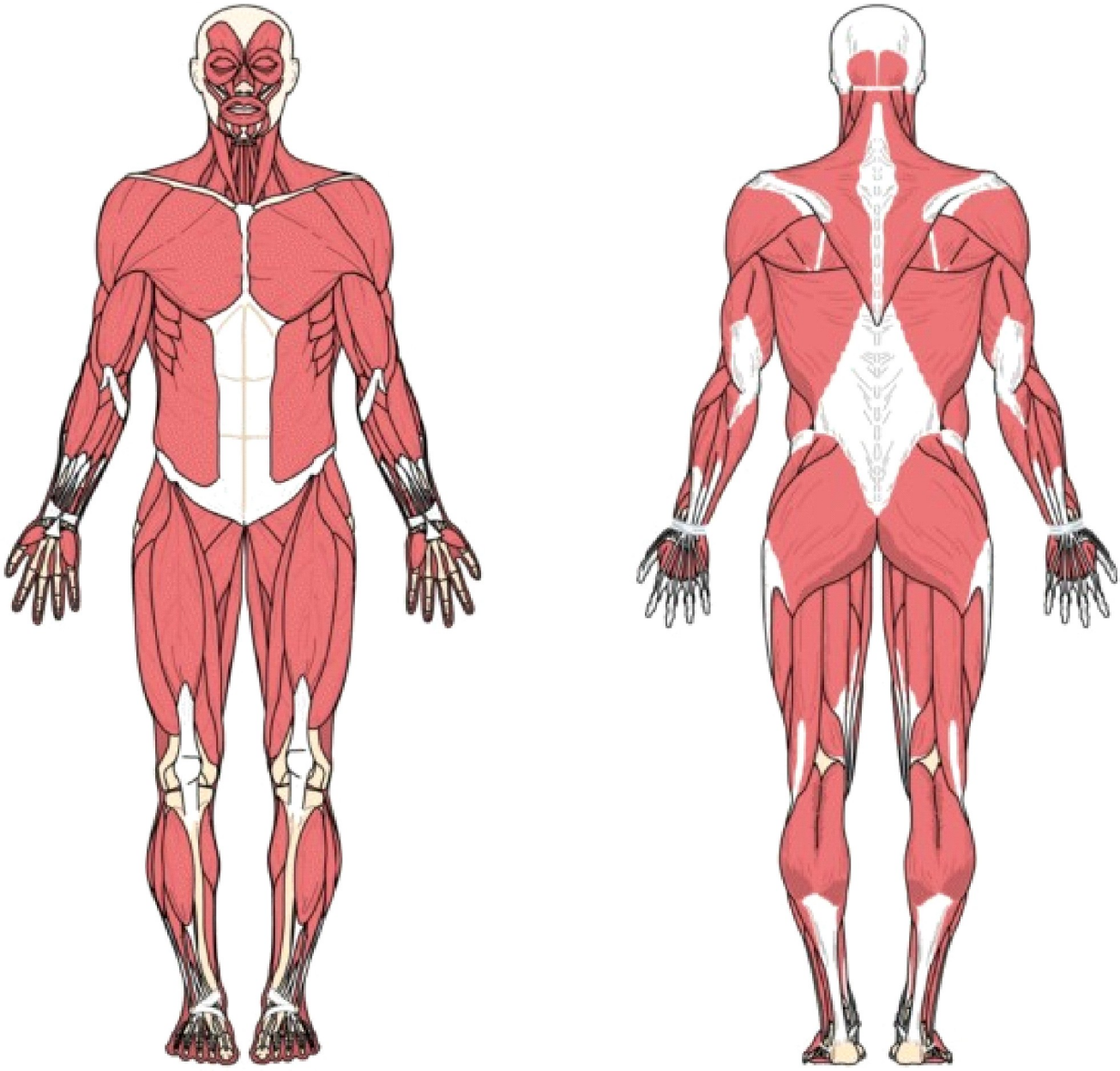
PAIN DRAWING ASSESSMENT

Carefully draw the location of your pain on the body outlines below.
Include ALL areas of pain and radiation of pain. Use the following symbols:

Ache = Z Burning = B Numbness = X Pins & Needles = + Stabbing = /



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