TEMECULA PAIN MANAGEMENT

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NEW PATIENT VISIT

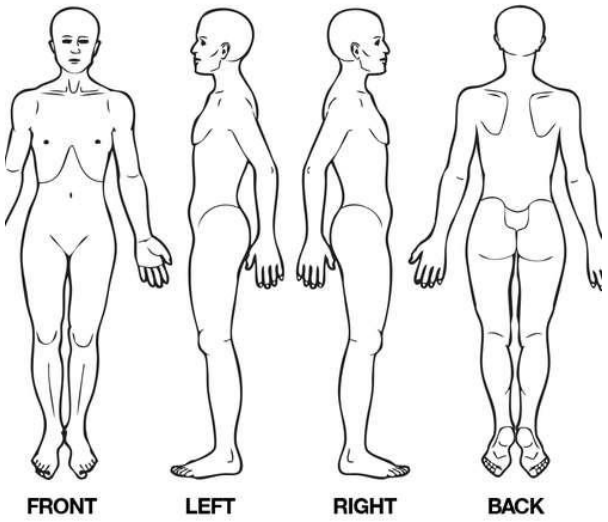
Name_____ **Date of Visit:** _____ **DOB:** _____

Height _____ **Weight**_____

What is the main problem for which you are seeking treatment? _____

_____

1. Where is your pain located? (Show on diagram)



2. How long have you had this pain? _____

3. How did it start? _____

4. Is it constant or intermittent? (Please Circle)

5. How do you describe the pain? (Please check)

☐ Aching	☐ Electric Shock	☐ Pins/Needles	☐ Shooting	☐ Tightness
☐ Burning	☐ Heavy	☐ Pressure-Like	☐ Stabbing	☐ Tingling
☐ Cramping	☐ Knife-Like	☐ Pounding	☐ Stinging	
☐ Dull	☐ Numbness	☐ Sharp	☐ Throbbing	

6. Where does the pain radiate to? **Left:** ☐ **Right:** ☐ **Both:** ☐

☐ Buttocks	☐ Arm	☐ Hip	☐ Knees	☐ Foot
☐ Shoulder	☐ Hand	☐ Legs	☐ Ankle	☐ Toes

7. Severity of pain at its worst? 0 1 2 3 4 5 6 7 8 9 10

8. Severity of average pain? 0 1 2 3 4 5 6 7 8 9 10

9. What makes the pain worse?

☐ Bending	☐ Defecation	☐ Lifting	☐ Sit-to-stand Transfers	☐ Stress
☐ Bowel Movements	☐ Driving	☐ Looking Up	☐ Sitting too long	☐ Turning Left
☐ Changing Positions	☐ Going downstairs	☐ Menses	☐ Sneezing	☐ Turning Right
☐ Coughing	☐ Heat	☐ Movement	☐ Standing too long	☐ Turning Side-to-side
☐ Cold Weather	☐ Increased Activity	☐ Physical Activity	☐ Standing straight up	☐ Walking
☐ Climbing Stairs	☐ Laying Flat	☐ Sexual Activity	☐ Sleeping	☐ Weather Change

10. What makes the pain better?

☐ Assistive devices	☐ Hot Baths	☐ Leaning back	☐ Pool therapy	☐ Standing
☐ Acupuncture	☐ Ice	☐ Massage	☐ Rest	☐ Swimming
☐ Change in positions	☐ Injections	☐ Medications	☐ Squatting	☐ TENS Unit
☐ Cold pack	☐ Inversion Table	☐ Moving Around	☐ Stretching	☐ Walking
☐ Exercising	☐ Leaning Forward	☐ Physical Therapy	☐ Sitting	☐ Laying Down

11. Associated Symptoms

☐ Difficulty with sleep	☐ Need for sleeping pills	☐ Restricted activities	☐ Depression
☐ Feeling Blue	☐ Non restful sleep	☐ Unable to fall asleep	☐ Weight Loss
☐ Frustrated	☐ Fevers	☐ Unable to stay asleep	☐ Headaches
☐ Loss of bowel/bladder function	☐ Chills	☐ Waking up	
☐ Muscle cramps	☐ Sweats	☐ Weakness	

12. Do you feel numbness and or pins & needles in association with your pain?

No: ☐ If Yes: ☐ Numbness

☐ Pins and needles

13. Do you have weakness? No: ☐ If yes check boxes below:

Arms: ☐ Right: ☐ Left: ☐

Legs: ☐ Right: ☐ Left: ☐

Do you drop objects? No: ☐ Yes: ☐

Have you fallen recently? No: ☐ Yes: ☐

Do you have balance problems? No: ☐ Yes: ☐

14. How many blocks can you walk?

- ☐ Less than 1
- ☐ 2
- ☐ 3
- ☐ 4 or more

15. How often during the day do you have to rest because of the pain?

- ☐ Never
- ☐ Seldom
- ☐ Sometimes
- ☐ Often
- ☐ Constantly

16. Sleep Disturbance

Do you have difficulty falling asleep? No: ☐ Yes: ☐

Do you have difficulty remaining asleep? No: ☐ Yes: ☐

Are you ever awakened by pain? No: ☐ Yes: ☐

On average how many hours do you sleep? _____ hrs

17. How long can you sit?

- ☐ Less than 15 minutes
- ☐ Up to 30 minutes
- ☐ Up to 1 hour
- ☐ 1 – 2 hours
- ☐ 2 hours or more

18. To assist walking, I use a:

- ☐ No assistance device
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair

19. How long can you stand?

- ☐ Less than 15 minutes
- ☐ Up to 30 minutes
- ☐ Up to 1 hour
- ☐ 1 – 2 hours
- ☐ 2 hours or more

20. Which activities of daily living are affected by your pain? (check all that apply)

- ☐ Socialize with friends
- ☐ Participate in recreational activities
- ☐ Go to work
- ☐ Dress, or bath
- ☐ Perform household chores
- ☐ Exercise
- ☐ Other: _____

21. Do you have any of the following (Please check)

Dizziness/vertigo: ☐ Fibromyalgia: ☐

22. Who have you seen for this pain? _____

Have you seen a neurosurgeon? If yes, who and when? _____

23. What tests/imaging have you undergone? _____

24. What treatment have you tried in the past for your pain (Please check your response to all treatments you have tried)

Physical Therapy	☐ No Relief	☐ Some Relief	☐ Good Relief
TENS Therapy	☐ No Relief	☐ Some Relief	☐ Good Relief
Pool Therapy	☐ No Relief	☐ Some Relief	☐ Good Relief
Biofeedback	☐ No Relief	☐ Some Relief	☐ Good Relief
Pain Management	☐ No Relief	☐ Some Relief	☐ Good Relief
Psychiatric Therapy	☐ No Relief	☐ Some Relief	☐ Good Relief
Epidurals	☐ No Relief	☐ Some Relief	☐ Good Relief
Acupuncture	☐ No Relief	☐ Some Relief	☐ Good Relief
Chiropractic Manipulations	☐ No Relief	☐ Some Relief	☐ Good Relief
Spine Surgery	☐ No Relief	☐ Some Relief	☐ Good Relief
Nerve Blocks	☐ No Relief	☐ Some Relief	☐ Good Relief
Other: _____	☐ No Relief	☐ Some Relief	☐ Good Relief
Other: _____	☐ No Relief	☐ Some Relief	☐ Good Relief
Other: _____	☐ No Relief	☐ Some Relief	☐ Good Relief

25. Do you experience any of the following?

Constitutional

☐ Fever ☐ Chills ☐ Hot Flashes ☐ Night Sweats ☐ Weight Loss

Eyes

☐ Blurred Vision ☐ Double Vision ☐ Photophobia

HENT

☐ Loss of Balance ☐ Syncope ☐ Deafness/hearing loss ☐ Head injuries

Cardiovascular

☐ MI ☐ Chest Pain ☐ Irregular Heartbeat ☐ High BP ☐ Limb Swelling
☐ Phlebitis ☐ DVT ☐ PVD ☐ Angina ☐ CHF

Respiratory

☐ Shortness of breath ☐ COPD/Emphysema ☐ Sleep Apnea ☐ Asthma

Gastrointestinal

☐ Heart Burn ☐ Nausea/Vomiting ☐ Diarrhea ☐ Constipation ☐ Bloody Stool
☐ Ulcers ☐ GERD ☐ Jaundice/Hepatitis

Genitourinary

☐ Blood in Urine ☐ Kidney Failure ☐ Bladder problems ☐ Kidney Stones ☐ Problem Urinating

Musculoskeletal

☐ Muscle Pain ☐ Muscle cramps ☐ Muscle twitches ☐ Neck pain ☐ Loss of muscle bulk
☐ Back pain ☐ Joint pain ☐ Joint stiffness ☐ Joint swelling ☐ Tremors
☐ Fractures ☐ Arthritis ☐ Limitation of joint movement ☐ Night cramps ☐ Posture abnormalities

Neurological

☐ Headache ☐ Seizures ☐ Blackouts ☐ Trouble W/Memory ☐ Trouble Concentrating
☐ Decrease in Cognitive skills ☐ Stroke ☐ Involuntary movements ☐ Speech Difficulties ☐ Spasticity

Psychological

☐ Depression ☐ Anxiety ☐ Family History of Psychiatric Disorder

Hematologic

☐ Abnormal Bleeding ☐ Anemia ☐ Blood Clotting ☐ DVT/PE ☐ High/low Blood Counts

Endocrine

☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes

26. List all medications you are taking now with the dose and times taken per day.

Name	Dose	Per Day

Are you taking any blood thinner medications? YES_____ NO_____

If yes, which ones? ☐ **Coumadin.** ☐ **Plavix** ☐ **Lovenox** ☐ **Eliquis** ☐ **Xarelto**

27. Allergies?

	No	**YES**	**What was the Reaction?**
Adhesive Tape	_____	_____	_____
IV Contrast/Dye	_____	_____	_____
NSAIDs	_____	_____	_____
Opiates? Which?	_____	_____	_____
Penicillin	_____	_____	_____
Sulfa	_____	_____	_____
Others?_____	_____	_____	_____

28. Past Medical History / Problem List

Mark all conditions/diseases that **YOU** have been **DIAGNOSED** with:

Cardiovascular/Hematologic
- ❑ Anemia
- ❑ Coronary Artery Disease
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker/Defibrillator
- ❑ Poor Circulation
- ❑ Stroke

Gastrointestinal
- ❑ Bowel Incontinence
- ❑ Constipation
- ❑ Gastrointestinal Bleeding
- ❑ GERD (Acid Reflux)

General Medical
- ❑ Cancer- Type _____
- ❑ Diabetes- Type _____
- ❑ HIV/AIDS

Head/Eyes/Ears/Nose/Throat
- ❑ Glaucoma
- ❑ Headaches
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Migraines

Hepatic-list active inactive unsure

Hepatitis ❑ A ❑ B ❑ C

❑ active ❑ inactive ❑ unsure

Musculoskeletal
- ❑ Amputation/Phantom Limb Pain
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Low Back Pain
- ❑ Chronic Joint Pain
- ❑ Chronic Neck Pain
- ❑ Fibromyalgia
- ❑ Joint Injury _____
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Rheumatoid Arthritis
- ❑ Tennis Elbow
- ❑ Vertebral Compression Fracture

Nephrology/Genitourinary
- ❑ Bladder/Kidney Infections
- ❑ Dialysis
- ❑ Kidney Stones
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Urinary Incontinence

Neuropsychological
- ❑ Alcohol Abuse
- ❑ Alzheimer Disease
- ❑ Anxiety
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Multiple Sclerosis
- ❑ Neuropathy
- ❑ Paralysis
- ❑ Prescription Drug Abuse
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Reflex Sympathetic Dystrophy (RSD)/ Chronic Regional Pain Syndrome (CRPS)
- ❑ Spinal Cord Injury
- ❑ Traumatic Brain Injury (TBI)

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Chronic Obstructive Pulmonary Disease (COPD)
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Tuberculosis (TB)
- ❑ Valley Fever

Other diagnosed conditions:

_____

_____

_____

_____

_____

_____

❑ I HAVE NO SIGNIFICANT MEDICAL HISTORY

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ❑ Yes ❑ No

If so, have you ever had any adverse reaction to anesthesia? ❑ Yes ❑ No

Which type of anesthesia did you react adversely to? Please check all that apply.

❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV sedation

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?

❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV sedation

29. Past Surgical History:

Please indicate any surgical procedures you have had done in the past, including the date, type or other pertinent details:

Abdominal Surgery

❑ Gallbladder removal_____
❑ Appendectomy _____
❑ Other _____

Joint Surgery

❑ Hip _____
❑ Knee _____
❑ Shoulder _____
❑ Other _____

Heart Surgery

❑ Aneurysm repair _____
❑ Stent placement _____
❑ Valve replacement _____
❑ Other _____

Spine/Back Surgery

❑ Discectomy (levels)_____
❑ Laminectomy _____
❑ Spinal Fusion (levels) _____
❑ Other _____

Other Common Surgeries

❑ Hemorrhoid surgery _____
❑ Hernia repair _____
❑ Thyroidectomy _____
❑ Tonsillectomy _____
❑ Vascular surgery _____

Other?

❑ Other _____
❑ Other _____
❑ Other _____

30. Do you drink alcohol? Yes: ☐ No: ☐ **If yes how often? _____**

31. Smoke cigarettes? Yes: ☐ No: ☐ **If yes how much? _____**

Former Smoker? Yes: ☐ No: ☐ **If yes, how many years? _____**

32. Do you use nonprescription drugs? If yes, which ones? _____

33. Have you ever had a history of drug or substance abuse? Yes: ☐ No: ☐

34. Marital status? _____

35. Are you currently working? Yes: ☐ No: ☐ **What kind of work do you do?** _____

Are you on disability? Yes: ☐ No: ☐ **Are you pregnant?** Yes: ☐ No: ☐

36. Does anyone in your family have a history of related medical problems? What Problems?

_____

_____

37. Preferred Pharmacy

Pharmacy Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

38. Are you currently involved in litigation or a lawsuit related to your pain?

_____

PATIENT SIGNATURE: _____ DATE: _____