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? ____________________________________

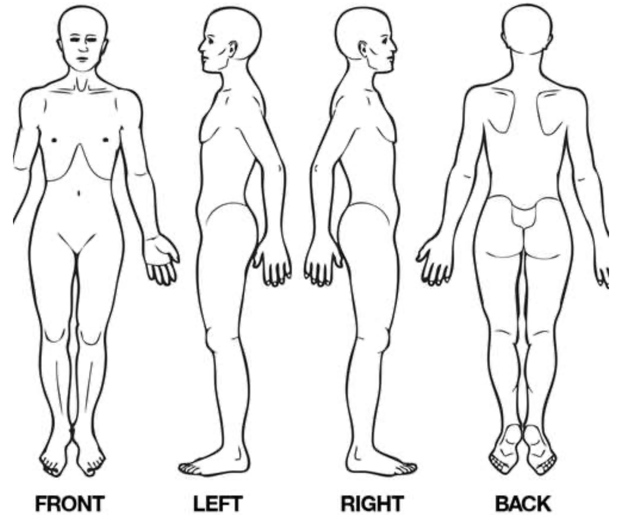
____

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

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

- ☐ Buttocks
- ☐ Shoulder
- ☐ Arm
- ☐ Hand
- ☐ Hip
- ☐ Legs
- ☐ Knees
- ☐ Ankle
- ☐ Foot
- ☐ 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
- ☐ Bowel Movements
- ☐ Changing Positions
- ☐ Coughing
- ☐ Cold Weather
- ☐ Climbing Stairs
- ☐ Defecation
- ☐ Driving
- ☐ Going downstairs
- ☐ Heat
- ☐ Increased Activity
- ☐ Laying Flat
- ☐ Lifting
- ☐ Looking Up
- ☐ Menses
- ☐ Movement
- ☐ Physical Activity
- ☐ Sexual Activity
- ☐ Sit-to-stand Transfers
- ☐ Sitting too long
- ☐ Sneezing
- ☐ Standing too long
- ☐ Standing straight up
- ☐ Sleeping
- ☐ Stress
- ☐ Turning Left
- ☐ Turning Right
- ☐ Turning Side-to-side
- ☐ Walking
- ☐ 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 upcoming appointments related to this pain?

____

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)

Treatment			
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 list any surgeries you have had in the past, including the date/year, type or other pertinent details (e.g. left or right):

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 much?** ____________________

31. Smoke cigarettes? Yes: ☐ No: ☐ **If yes how much?** _________ **# years?** _______

Former Smoker? Yes: ☐ No: ☐ **If yes how much?** _________ **# years?** _______

32. Do you use recreational 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/lawsuit related to your pain?

____

39. Are you currently involved in workers' compensation related to your pain?

____

40. Do you want the option of receiving telehealth services from us in the future? See below

______ YES ______ NO

PATIENT SIGNATURE: __________________________ DATE: ____________________

TELEHEALTH PATIENT CONSENT

Under some insurances (including Medi-Cal) you have the option to receive services in person in a face-to-face visit or telehealth. If you have trouble accessing in-person services due to transportation, Medi-Cal provides coverage for transportation services when other resources have been reasonably exhausted. There may be limitations or risks related to receiving services through telehealth rather than in person, such as limited physical exam leading to possibly missed diagnoses. If you choose to receive services by telehealth, you may change your mind at any time by letting us know. If you change your mind about using telehealth, you will still have access to services covered by your insurance. Knowing all of this, please indicate above whether you would like telehealth services as an option.