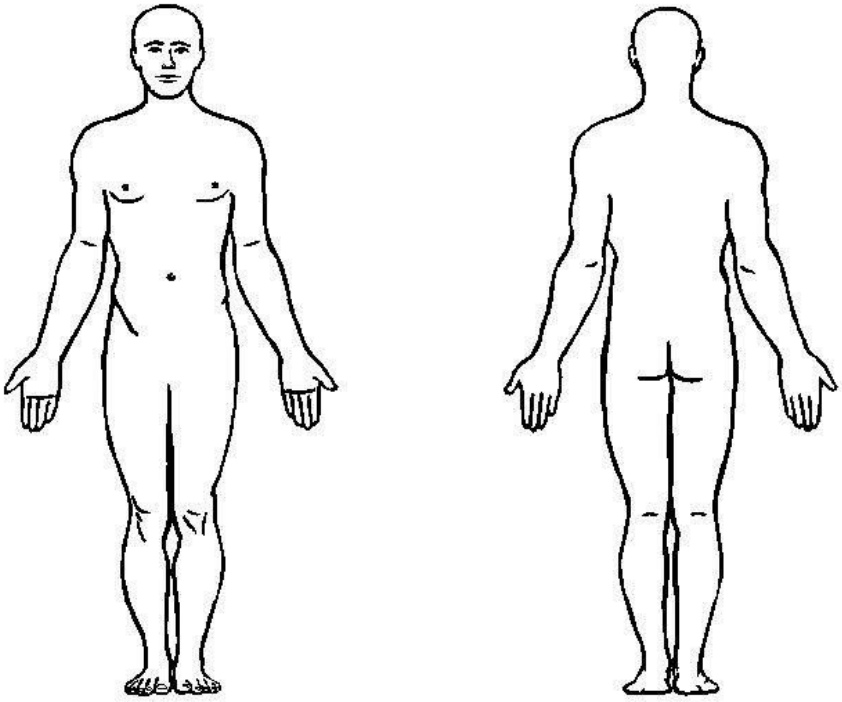
RELIEVE
Pain Center

Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Sex: Male / Female Height: _____Weight: _____
Referring Physician: _____ Reason for Referral: _____

**PAIN ASSESSMENT**

When did your pain start? _____
How did your pain start? _____
If you were injured, please describe: _____
What aggravates your pain? _____
What relieves your pain? _____
Describe your pain, circle all that apply, and mark the location of your pain on the body:



| | | | | | |
|---|---|---|---|---|---|
| Sharp | Stabbing | Throbbing | Dull | Aching | Squeezing |
| Stretching | Cramping | Shooting | Localized | Diffuse | Stiff |
| Redness | Swelling | Heat | Immobility | Burning | Pins & Needles |

Does the pain radiate anywhere? Yes / No Where? _____
Is the pain constant or intermittent? (circle one)
Please list any other symptoms associated with the pain: _____

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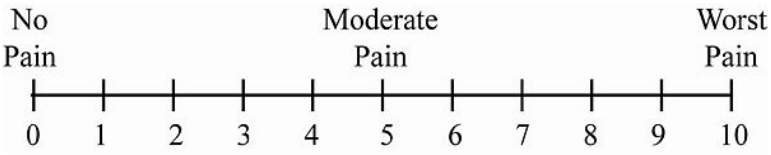
What is the severity of the pain? (please circle)




Do you have the following symptoms? If yes, please describe and provide the location.

- Numbness or Tingling: _____
- Weakness: _____
- Bowel or Bladder Problems: _____

What is your activity level? _____
How far can you walk? _____ How long can you stand? _____

What are your goals? _____

Over the **last 2 weeks**, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things (please circle answer)
   Not at all  Several days  More than half the days  Nearly every day
2. Feeling down, depressed or hopeless (please circle answer)
   Not at all  Several days  More than half the days  Nearly every day

**PRIOR TREATMENTS**

Physical Therapy?  Yes / No
When? _____  Results: _____

Injections?  Yes / No
What kind? (Results) _____
When? Where? Who was the Physician? _____

Surgery?  Yes / No
What kind? (Results) _____
When? Where? Who was the Physician? _____

Please describe any other treatments you have tried: counseling, chiropractor, acupuncture, massage, biofeedback, other pain program: _____
_____

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Consultations – Please list all physicians you have seen concerning your pain problem. Please include their specialty, dates, and outcomes of the treatment: _____

_____

_____

**REVIEW OF SYSTEMS**

| System | Symptom | Please Explain |
|---|---|---|
| General | Fever, Chills, Night Sweats, Unintentional Weight Loss, Fatigue, Malaise | |
| Eyes | Visual Changes, Double Vision, Blurry Vision, Headache, Eye Pain | |
| ENT | Runny Nose, Nose Bleeds, Sinus Pain, Tinnitus, Sore Throat, Painful Swallowing | |
| Cardiovascular | Chest Pain, Irregular Heart Rate, Exercise Intolerance, Leg Swelling | |
| Pulmonary | Persistent Cough, Bloody Cough, Sputum, Wheeze, Shortness of Breath | |
| Gastrointestinal | Abdominal Pain, Constipation, Vomiting, Diarrhea, Bloating, Bloody Stools | |
| Genitourinary | Incontinence, Urgency, Dysuria, Discharge, Pelvic Pain | |
| Musculoskeletal | Joint Pain, Muscle Pain, Stiffness, Decreased Range of Motion, Crepitus | |
| Integumentary | Rashes, Skin Lesions, Itchy Skin, Excessive Dryness | |
| Neurologic | Sensory Changes, Seizures, Headaches, Poor Balance, Speech Problems | |
| Psychiatric | Depression, Anxiety, Paranoia, Mania, Personality Changes | |
| Hematologic | Anemia, Easy Bleeding, Easy Bruising, Hemophilia, Anticoagulant Use | |

**PAST MEDICAL HISTORY**

Do you have any drug allergies? (describe) _____
Please list all your current medical problems: _____

_____

_____

Do you have a pacemaker? Yes/No Is the pacemaker MRI compatible? Yes/No

Are you taking any other Blood Thinners? Yes / No Please list: _____

Please list all hospitalizations and dates: _____

_____

Please list all prior surgeries and dates: _____

_____

Have you had any anesthesia complications? If so, please describe: _____
Current Medications. Please list medication, dose, and prescribing physicians.

_____

_____

_____

**FAMILY HISTORY**

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Mother: Living / Deceased Health Issues: _____

Father: Living / Deceased Health Issues: _____

Children: Living / Deceased Health Issues: _____

Siblings: Living / Deceased Health Issues: _____

**SOCIAL HISTORY**

Are you married? YES / NO

Do you have children? YES / NO How many children and ages: _____

Do you smoke? YES / NO How many cigarettes per day: _____ How many years? _____

Do you drink alcohol? YES / NO How many drinks per day: _____

Do you currently use or have you ever used illicit drugs? YES / NO

If yes, which drugs: _____

Occupation: _____

Current Employer: _____

Highest Level of Education: _____

Patient Signature:

_____

*********** for office use only **********

| | |
|---|---|
| Imaging | XR MRI CT body part: |
| Procedure | CESI LESI tf-ESI TPI SI Joint Injx. MBB RFA PRP Other Level:<br>Imaging: Fluoro - U/S Sedation: local - oral - IV Location: Office - Surgery Center: |
| Surgery | SCS Trial SCS Implant Pump Trial Pump Implant ISS Kyphoplasty SI fusion |
| Referral | Neurology EMS/NCS Psych Rheum Addiction Ortho Neurosurgery PT Other |
| DME | LSO Traction TENS Other |
| Follow-up | 4 weeks 8 weeks PRN Post-op Other: |
| Insurance | PPO HMO: _____ Medicare VA Tricare WC |

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