Flower Mound INTERVENTIONAL PAIN PHYSICIANS & ANESTHESIA SERVICES

NEW PATIENT QUESTIONNAIRE

How did you hear about us? _____

Who is your PCP?_____

Send today's visit information to your PCP? **YES** **NO**

What/Where is your main PAIN problem(s)? **How long?**

_____ _____

_____ _____

How severe is your pain? (0 is no pain, 10 is the worst pain you ever felt in your life)

Right now_____ Average _____

How did your pain start (CIRCLE) all that applies to you

Suddenly *Gradually*

While bending *While walking* *When fell down* *Other* _____

While jumping *While lifting weight* *After car accident* *While playing*

How often do you have pain? Constant Intermittent

What is the pain like?

Achy *Sore* *Cramping* *Dull* *Throbbing*

Numb *Stabbing* *Pressure* *Sharp* *Shooting*

Pins/needles *Hot/burning* *Tingling* *Other* _____

Does your pain radiate or shoot to another location? NO

Left Head *Right head* *Trunk* *Other*_____

Left Arm *Right arm* *Flank*

Left Leg *Right leg* *Groin*

What makes your pain worse? NOTHING

Bending *Sitting a long time* *Going up stairs* *Turning left*

Lifting *Standing a* long time *Going down stairs* *Turning right*

Movement *Standing straight up* *Increased activity* *Walking*

*Other*_____

What makes your pain better? NOTHING

Medications *Massage* *Heat* *Walking* *Other:*_____

Injections *Exercise* *Cold* *Manipulation*

Physical therapy *Rest* *Sitting* *Standing* *Lying flat*

Are you having any of these associated symptoms? NONE

Muscle Cramps *Poor Sleep* *Loss of bowel/bladder control*

Weakness *Feeling sad*

Numbness *Feeling frustrated*

Do you have a history of these conditions? Fibromyalgia, IBS, Rheumatoid Arthritis

Do you use any supporting devices? Cane Crutches Walker Wheelchair

Has your pain decreased your *social, recreational and sexual activities*?

NONE MILDLY MODERATELY SEVERELY COMPLETELY

Medicines tried for pain control prior to your arrival here today:

Oral medications:	oral steroids	Tylenol,	ibuprofen,	diclofenac,	naproxen,	other NSAIDs,
Muscle relaxants:	baclofen,	tizanidine,	Flexeril,	Skelaxin,	Robaxin,	Soma, diazepam
Neuropathic meds:	amitriptyline ,	nortriptyline,	Neurontin,	gabapentin,	Lyrica	pregabalin
Other meds:	Effexor,	Cymbalta,	Topamax,	tramadol,	Ultram,	Savella
Opioids:	morphine,	MS Contin,	hydrocodone	Lortab,	vicodin,	norco
	OxyContin,	Percocet,	oxycodone,	Dilaudid,	fentanyl patch,	
	Opana,	Suboxone,	methadone,	codeine	Embeda	Kadian

Others: _____

Have you had any of these conservative treatments? NONE

Physical Therapy TENS unit Ultrasound Acupuncture Chiropractic manip

FOR NECK OR LOW BACK PAIN-- Have you had any interventions done? NONE

Epidural steroids Facet Injections Sacroiliac injections

Joint injections Spinal cord stimulation Trigger point injections

Do you exercise and stretch? Never Occasionally Weekly 2-3 times a week Daily

What caregivers you have visited for you pain?

Pain Physician Chiropractor Other_____

Primary Care Physician Rehab Specialist

Spine Surgeon Neurologist

Physical Therapist Rheumatologist

Are you pregnant? (Or is there a chance you could be pregnant?) YES NO

Have you had any X-rays, MRI, CT Scans, EMGs, Discograms, or other diagnostic studies? Where at?

_____

_____

List any medication or iodine ALLERGIES

_____

_____

CURRENT MEDICATIONS YOU ARE TAKING

_____

_____

_____

_____

_____

_____

_____

YOUR MEDICAL HISTORY-list major medical conditions

_____

_____

_____

_____

_____

_____

_____

PAST SURGERIES UNDERGONE

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY-list major conditions

_____

_____

_____

_____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? YES NO	**How Much?** Social <1 drink/day _____ drinks per day
Do you use any street drugs (cocaine, MJ, etc)? YES NO	What and when last used?
How much smoking daily? _____ packs per day, for _____ years	If quit, when?
Marital Status: Single Married Divorced Widowed	
Are you working currently? YES NO	If not, when worked last? _____
What is/was your occupation? _____	
Are you applying for disability? YES NO	
Are you currently on disability or workman's comp? YES NO	
Are you involved in any legal proceedings or lawsuits? YES NO	

REVIEW OF SYSTEMS (Do you have any of these symptoms?)

Constitutional:	fever	weight gain	weight loss	
Ears:	ear discharge	dizziness	earaches	
Head/Neck/Eyes:	visual changes	headaches	neck pain	pain in eyes
Nose/Throat:	nosebleeds	hoarseness	swallowing difficulty	
Cardiovascular:	chest pain irregular heart beat	leg swelling palpitations	poor circulation high blood pressure	blood clots
Respiratory:	coughing	wheezing	asthma	
Gastrointestinal:	heartburn stomach ulcer	nausea/vomiting diarrhea	painful bowel movement constipation	
Musculoskeletal:	muscle cramps stiffness	muscle twitches cold-weather pain	arthritis	swollen joints
Skin:	rash	shingles	itching	
Neurological:	weakness	numbness	tremors	poor coordination
Psychiatric:	depression	anxiety	mood swings	irritability
Hematologic:	easy bruising	anemia		
Endocrine:	excessive thirst	excessive urination	heat/cold intolerance	
Urinary:	painful urination	loss bladder control	blood in urine	kidney stones
Men only:	prostate trouble	erectile dysfunction		
Women only:	irregular periods	menstrual cramps	vaginal discharge	menopausal

Any other symptoms you would like to discuss? _____

What is your goal for pain management? _____

Do you feel any of these would be helpful?

- **Getting a TENS unit?**
- **Getting a brace- back, knee, wrist, elbow, etc?**
- **Getting a referral to a chiropractor?**
- **Getting a referral to physical therapy?**