Redding Pain Medicine

Date_____

Name: _____ **Preferred name:**_____ **DOB:**_____

DESCRIBE THE PAIN PROBLEM FOR WHICH YOU WERE REFERRED

_____

_____

_____

_____

Who referred you?_____ **Who is your PCP**?_____

When did you first notice your pain? _____

When did you first seek medical attention? _____

Have you been given a diagnosis or cause of your pain?

_____

What started the pain?

○ Accident / Injury ○ Following illness / Surgery ○ Pain just began, no reason

Describe details:_____

_____

Is the pain work-related? ○ YES ○ NO

Describe details:_____

_____

Since your pain began, has it:

○ Increased ○ Decreased ○ Stayed the same

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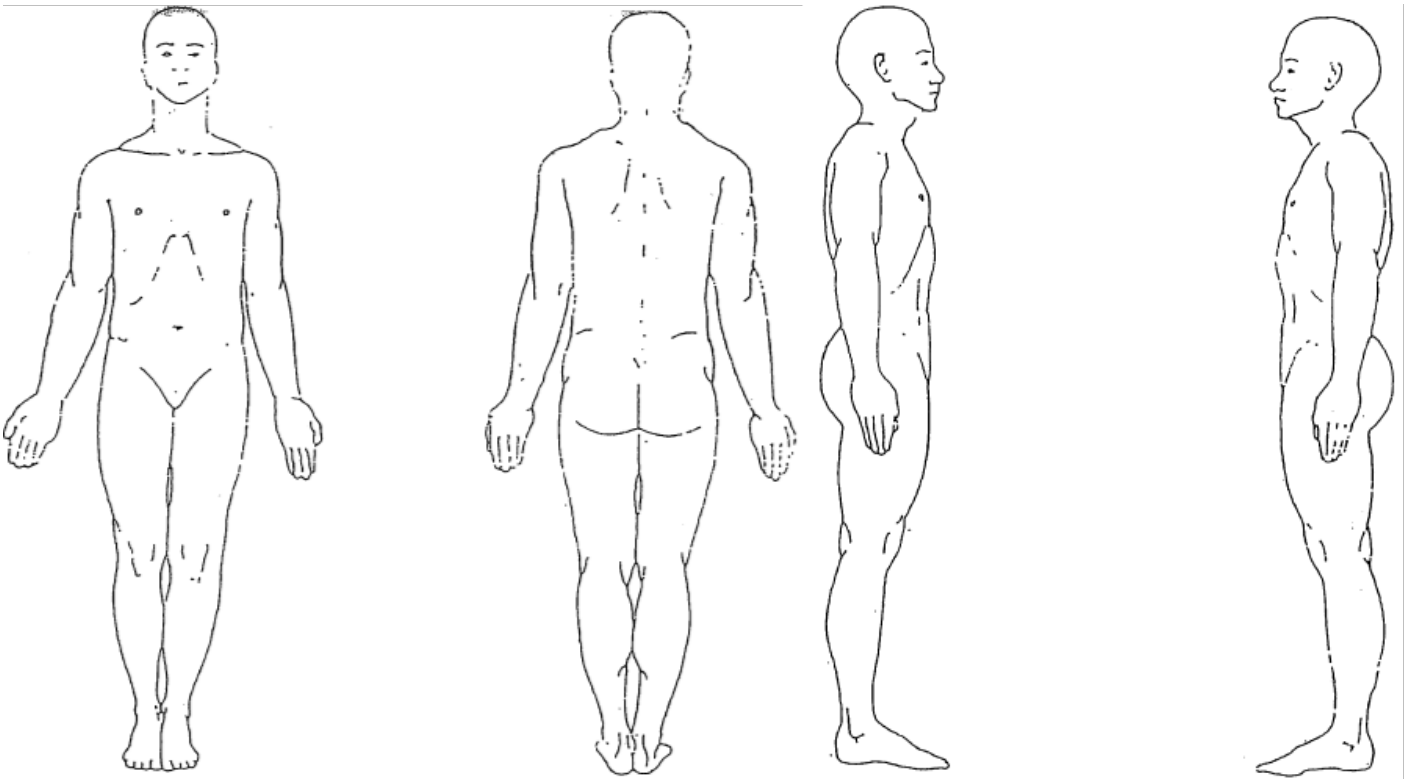
Indicate the areas where the pain occurs by shading on each diagram.

PLEASE BE PRECISE



Does the pain travel (radiate) anywhere? ○ YES ○ NO

DESCRIBE DETAILS:

PAIN SEVERITY

Circle the lowest and the highest pain in the last week:

no pain 0 ———1———2———3———4———5———6———7———8———9———10 most pain

Your pain at the present moment:

no pain 0 ———1———2———3———4———5———6———7———8———9———10 most pain

Statements that apply to your pain:

- ○ SOMETIMES PRESENT
- ○ USUALLY PRESENT
- ○ ALWAYS PRESENT
- ○ INTENSITY VARIES
- ○ ALWAYS THE SAME INTENSITY
- ○ INTERMITTENT

What time of day is your pain worst?

- ○ PAIN VARIES, NOT WORSE AT ANY PARTICULAR TIME
- ○ PAIN IS ALWAYS THE SAME
- ○ MORNING, OR ARISING
- ○ AFTERNOON
- ○ EVENING
- ○ NIGHT (DURING SLEEP HOURS)

How long can you sit? _____

How long can you stand? _____

How far can you walk without stopping? _____

PAIN DESCRIPTION

Would you describe your pain as (mark any that apply):

BURNING	SHARP	ACHING
TIGHT	THROBBING	PULLING
SHOOTING	STABBING	ELECTRICAL
OTHER:_____		

In the affected area do you have? (mark any that apply)**:**

NUMBNESS	WEAKNESS	COLDNESS
MUSCLE SPASMS, TIGHTNESS	TINGLING, PINS AND NEEDLES	INCREASED SWEATING
INCREASED SKIN SENSITIVITY	SKIN COLOR CHANGES	

Do any of the following make your pain feel worse? (mark any that apply):

COUGHING, SNEEZING	WALKING
SITTING	PHYSICAL ACTIVITY
LYING DOWN	SEXUAL ACTIVITY
STANDING	OTHER:_____

Do any of the following ease your pain? (mark any that apply):

RELAXATION	WALKING	SITTING
PHYSICAL ACTIVITY	STANDING	SEXUAL ACTIVITY
LYING DOWN	ALCOHOLIC DRINKS	MEDICATION
HEAT	COLD	NOTHING HELPS
OTHER:_____		

Does pain interrupt your sleep? (choose one)

O NOT AT ALL O OCCASIONALLY O MORE THAN THREE TIMES PER NIGHT

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TREATMENT HISTORY

Who have you seen?

SPECIALTY	NAME OF PROVIDER
NEUROSURGEON / SPINE SURGEON	
NEUROLOGIST	
CHIROPRACTOR	
PHYSICAL THERAPIST	
ACUPUNCTURIST	
OTHER	
OTHER	

Which have you had:

TESTING	DATE AND WHERE
X-RAYS	
EMG/NCS (NERVE TESTING)	
CT SCAN	
MRI SCAN	
BONE SCAN	
ULTRASOUND	
OTHER	

Have you had spine or joint injections? ○ YES ○ NO

List:_____

If yes, name of doctor(s) who performed injection(s):_____

When was your last injection? _____

How did the injections affect your pain:

○ No Change

○ Better for a while. How long?_____

What other therapies have you tried for relief of your pain:

THERAPY	WHEN	HELPFUL	NON HELPFUL
PHYSICAL THERAPY			
CHIROPRACTIC TREATMENT			
SUPERVISED EXERCISE			
ACUPUNCTURE			
BED REST			
TRACTION			
HEAT / COLD THERAPY			
TRIGGER POINT INJECTIONS			
BIOFEEDBACK / COUNSELING			
MASSAGE			
SPINAL CORD STIMULATOR			
INTRATHECAL PUMP			
OTHER			

Last physical therapy or chiropractor visits:

Provider_____

Approximate number of visits_____

Date (month/day/year)_____

Have you received financial compensation related to your pain? O YES O NO

Have you sued for compensation for your pain? O YES O NO

Are you planning to sue because of your pain? O YES O NO

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List all medication you are currently taking.

(including nonprescription medicines and topicals)

○ I consent to the use of Surescripts® to update my current prescriptions.

MEDICATION	AMOUNT	HOW OFTEN?

What medications have you tried for your pain: (circle all)

NSAIDS

CELEBREX (CELOCOXIB)
MOBIC (MELOXICAM)
MOTRIN, ADVIL (IBUPROFEN)
NAPROSYN (NAPROXEN)
RELAFEN (NABUMETONE
TORADOL (KETOROLAC)
VOLTAREN (DICLOFENAC)
ASPIRIN

OPIOIDS

BUPRENORPHINE
TRAMADOL
CODEINE
HYDROCODONE
OXYCODONE
MORPHINE
HYDROMORPHONE
METHADONE
FENTANYL

NEUROPATHICS

TYLENOL (ACETAMINOPHEN)
LYRICA (PREGABALIN)
NEURONTIN (GABAPENTIN)
TOPAMAX (TOPIRAMATE)
TEGRETOL (CARBAMAZEPINE)
MEXITIL (MEXILITINE)
CLONIDINE

MUSCLE RELAXERS

BACLOFEN
FLEXERIL(CYCLOBENZAPRINE)
ZANAFLEX (TIZANIDINE)
ROBAXIN (METHOCARBAMOL)
SOMA (CARISOPRODOL)
MAGNESIUM

ANTI DEPRESSANTS

CYMBALTA (DULOXETINE)
PAMELOR (NORTRIPTYLINE)
TOFRANIL (IMIPRAMINE)
ELAVIL (AMITRIPTYLINE)
EFFEXOR (VENLAFAXINE)

STEROIDS

PREDNISONE
MEDROL (DEXAMETHASONE)
KENALOG (TRIAMCINOLONE)
DEPOMEDROL

TOPICALS

ZOSTRIX CREAM
QUTENZA
OTC CAPSAICIN
VOLTAREN (DICLOFENAC)
LIDOCAINE

Other

NALTREXONE
MEMANTINE
KETAMINE
DESYREL (TRAZODONE)
CBD
THC

○ **STEROID PILLS OR SHOTS IN THE LAST 12 MONTHS?**_____

Please list all medications you are allergic to.

○ **Not allergic to any drugs**

Allergic to:

_____

_____

_____

Circle if allergic to Latex Betadine Chlorhexidine Adhesives Contrast None

Do you have a history of problems with anesthesia? ○ YES ○ NO

Describe:_____

List all surgeries that you have had.

YEAR	SURGERY	SURGEON OR LOCATION

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MEDICAL HISTORY (circle all)

HIGH BLOOD PRESSURE (HYPERTENSION)	COPD; HOME O2
HEART DISEASE	SLEEP APNEA
STROKE	ASTHMA
DIABETES	GLAUCOMA
KIDNEY DISEASE	THYROID DISEASE
DEPRESSION / ANXIETY / PTSD	CANCER (_____)
HEPATITIS OR OTHER LIVER DISEASE	FREQUENT INFECTIONS
ARTHRITIS	MRSA
PACEMAKER / DEFIBRILLATOR	HEARING AID/ GLASSES

Other:_____

_____

_____

ARE YOU: O RIGHT-HANDED O LEFT-HANDED O AMBIDEXTROUS

YOUR HEIGHT: _____ YOUR WEIGHT: _____

Are you currently working? O YES O NO

What is your occupation?_____

O Retired. Previous occupation? _____

O Disabled. Previous occupation? _____

Who lives in your dwelling with you?_____

ARE YOU**:** O SINGLE O MARRIED O DIVORCED O WIDOWED

Do you use tobacco? O NOT AT ALL

AGE YOU BEGAN SMOKING?_____ FORMER SMOKER. LAST SMOKED? _____

CIGARETTES PER DAY? _____ PIPES / CIGARS YES / NO

CHEW OR VAPE YES / NO

Do you drink alcohol:

O NOT AT ALL

DRINKS PER DAY_____ DRINKS PER WEEK_____

HISTORY OF ALCOHOL ABUSE? YES / NO

Have you used any of the below in the last year:

O NONE
O METHAMPHETAMINE
O MARIJUANA
O HEROIN / OPIOIDS- NON PRESCRIBED
O COCAINE
OTHER_____

HAVE YOU BEEN TO REHAB? O YES O NO

FAMILY HISTORY

FATHER AGE_____ ❑ DECEASED

HEALTH PROBLEMS:_____

_____

MOTHER AGE_____ ❑ DECEASED

HEALTH PROBLEMS:_____

_____

SIBLINGS AGES_____ ❑ DECEASED_____

HEALTH PROBLEMS:_____

_____

Is there any family history of alcohol abuse? O YES O NO

Is there any family history of illegal drug abuse? O YES O NO

Is there any family history of prescription drug abuse? O YES O NO

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Have you had any of the following in the last 6 months? (Circle)

GENERAL

FEVER

WEIGHT LOSS

WEIGHT GAIN

INSOMNIA

FATIGUE

NIGHT SWEATS

RESPIRATORY

TROUBLE BREATHING

COUGHING UP BLOOD

WHEEZING

WAKING UP WITH TROUBLE BREATHING

PERSISTENT COUGH

ENLARGED LYMPH NODES

HEENT

BLURRED VISION

GLASSES / CONTACTS

RINGING IN THE EARS

SORE THROAT

DOUBLE VISION

HEARING PROBLEMS, USING A HEARING AID

NASAL DISCHARGE

EYE REDNESS

HEME

BLEEDING PROBLEMS

ALLERGY

SNEEZING

RUNNY NOSE

HAY FEVER

BURNING EYES

GI

DIARRHEA

BLOOD IN STOOLS

VOMITING UP BLOOD

ACID REFLUX / ESOPHAGITIS

CONSTIPATION

DARK, TARRY STOOLS

LOSS OF BOWEL CONTROL

SKIN

SKIN RASH	SKIN ULCERS
SKIN ERUPTIONS	ITCHING

MUSCULOSKELETAL

MUSCLE WEAKNESS	MUSCLE TREMOR
MUSCLE PAIN	SWOLLEN JOINTS

GU

HIATAL HERNIA	PAIN OR BURNING ON URINATION
BLOOD IN URINE	FREQUENT URINATION
FREQUENT URINARY TRACT INFECTION	LOSS OF BLADDER CONTROL

PSYCHIATRIC

DEPRESSION	ANXIETY
INSOMNIA	HALLUCINATIONS
OCD	BIPOLAR DISORDER
SCHIZOPHRENIA	ADD

NEUROLOGIC

HEADACHES	MEMORY LOSS
LOSS OF CONSCIOUSNESS	SEIZURES
DIZZINESS/VERTIGO	TINNITIS
FALLS	OTHER:

CARDIAC

DIZZINESS ON CHANGING POSITION	CHEST PAIN OR PRESSURE
PALPITATIONS OR IRREGULAR HEARTBEATS	

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