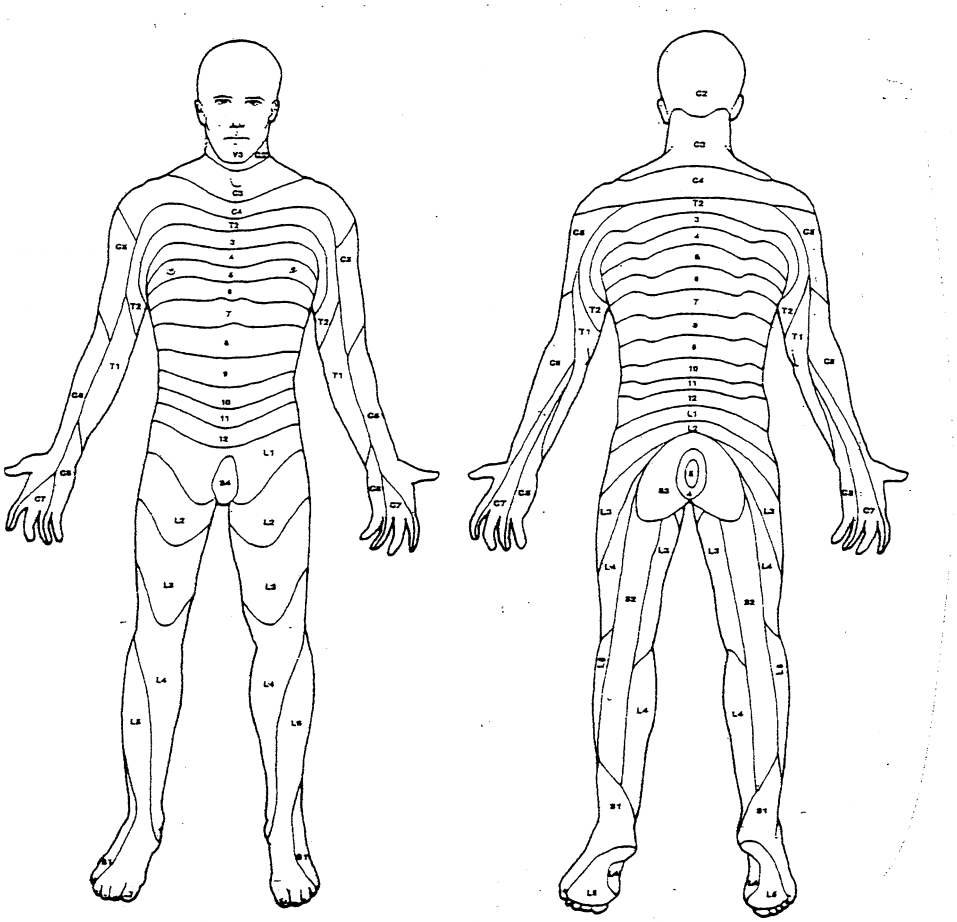
Name _____ *Date* _____

Referring MD _____ *Primary Care MD* _____

PLEASE SHADE IN THE AREAS WHERE YOU ARE EXPERIENCING PAIN:



By answering the following questions you will help your physician better understand and treat your pain.

1. What is the **main** complaint for which you are seeking treatment at the Pain Control Center?

_____

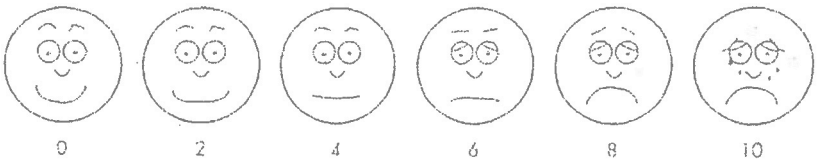
2. When did you first experience the pain for which are you now seeking help? _____
3. Under what circumstances did your pain begin?

_____ Accident at work
_____ Accident at home
_____ Other accident
_____ At work, but not an accident
_____ Following surgery
_____ Following illness
_____ Pain just began, can't relate to anything
_____ Other reasons or circumstances

Would you briefly describe the circumstances you checked above:

_____

_____



4. What is your pain level today?
   No Pain = 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Worst imaginable
5. How would you rate your **worst** episode of pain?
   No Pain = 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Worst imaginable
6. How would you rate your pain **on your best day***?*
   No Pain = 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Worst imaginable
7. What level of pain do you think you could function with on a daily basis?
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
8. Circle one: Continuous Pain ☐ Occasional Pain ☐
9. Please circle the word or words which best describe the character of your pain:

Burning ☐	Aching ☐	Pounding ☐	Tingling ☐
Shooting ☐	Stabbing ☐	Sharp ☐	Dull ☐
Cramping ☐	Throbbing ☐	Gnawing ☐	Numbing ☐

10. What time of day is your pain the worst?
    ☐ Morning ☐ Afternoon ☐ Evening ☐ Nighttime
11. Does your pain radiate? If so, where_____
12. Is your pain associated with weakness and/or numbness?_____
13. What type of activity makes your pain **better**? _____
14. What type of activity makes your pain **worse**? _____
15. Please circle the effects your pain has had on you:

Anxiety ☐	Weight Gain ☐	Nightmares ☐
Depression ☐	Loss of Appetite ☐	Lack of Concentration ☐
Weight Loss ☐	Insomnia ☐	Nervousness ☐

Patient Label Here

REVIEW OF SYSTEMS

Please check if you have/had problems related to the areas indicated.

	YES	NO
1. CONSTITUTIONAL		
Weight change	☐	☐
Fevers	☐	☐
Sweats	☐	☐
Fatigue	☐	☐
2. EYES		
Glaucoma	☐	☐
Cataracts	☐	☐
Vision surgery	☐	☐
3. EARS, NOSE, THROAT		
Loss of hearing	☐	☐
Dizziness	☐	☐
Nose bleeding	☐	☐
Gum bleeding	☐	☐
4. RESPIRATORY		
Chronic cough	☐	☐
Bronchitis	☐	☐
Shortness of breath	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
5. CARDIOVASCULAR		
Heart attack	☐	☐
Chest pain/angina	☐	☐
Heart murmur	☐	☐
Anemia	☐	☐
Transfusions	☐	☐
Phlebitis or blood clots	☐	☐
Rheumatic fever	☐	☐
6. GASTROINTESTINAL		
Reflux	☐	☐
Hepatitis A	☐	☐
Blood in stools	☐	☐
Diarrhea/constipation	☐	☐
Hernia/repair	☐	☐
Gall bladder disease	☐	☐

	YES	NO
7. Endocrine System		
Diabetes	☐	☐
Thyroid problem	☐	☐
Hormone treatment	☐	☐
Anabolic steroids	☐	☐
8. BREAST/GENITAL		
Menopause	☐	☐
Masses	☐	☐
Genital infections	☐	☐
9. URINARY SYSTEM		
Urinary tract/bladder infections	☐	☐
Kidney stones	☐	☐
Incontinence	☐	☐
Trouble urinating	☐	☐
Prostate problems	☐	☐
10. Skin		
Cancers	☐	☐
Rashes	☐	☐
11. NEUROLOGIC		
Stroke	☐	☐
Seizures	☐	☐
Head injury	☐	☐
Nerve damage	☐	☐
12. PSYCHIATRIC		
Depression	☐	☐
Anxiety	☐	☐
13. MUSCULOSKELETAL		
Osteoarthritis	☐	☐
Rheumatoid arthritis	☐	☐
Gout	☐	☐

OTHER _____

_____

_____

Patient Label Here

Medical History

1. Do you have or had any of the following medical problems? No _____ Yes _____ (check below)

_____ Glaucoma	_____Cirrhosis	_____ Osteoporosis
_____ Heart Disease -	_____Diabetes	_____ Cancer
Type: _____	_____Seizure Disorder	_____ Stomach Ulcers
_____ High Blood Pressure	_____Depression	_____ Migraine Headache
_____ Lung Disease -	_____Thyroid Disorder	_____ AIDS or HIV
Type: _____	_____Kidney Disease	_____ Broken Bones (list):
_____ Hepatitis - Type: _____	_____Arthritis	_____

Other: _____

2. Is there a family history of any of the above? Please explain: _____

_____

_____

_____

_____

3. Have you been seen in a Pain Center before? If so, where?
   Doctor's name _____ Phone Number_____ Dates_____

4. Please list any hospitalization or surgeries:
   Date Reason for Hospitalization/Type of Surgery Physician

_____

_____

_____

5. Are you allergic to any medications? Yes ☐ No ☐ Are you allergic to latex? Yes ☐ No ☐
   Are you allergic to foods, dye, tape, etc? Yes ☐ No ☐
   Please list: Reaction:

_____ _____

_____ _____

6. Are you taking any blood thinners? Yes ☐ No ☐ *If yes, what*? _____

7. Please list ***all medications*** you are **currently** taking, *including non-prescription drugs*, and how often you take each one:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

8. Please list pain medications you have taken in the past that were ineffective or caused side effects that you could not tolerate _____

_____

Patient Label Here

Previous Treatments

Since your pain began have you undergone any of the following treatments? Yes☐ No ☐

Please list dates and frequency:

Heating Pad	Epidurals
Ice Packs	Other Nerve Blocks
Physical Therapy	Trigger Point Injections
TENS Unit	Spinal Cord Stimulation
Traction	Work Hardening
Massage	Biofeedback
Chiropractic	Hypnosis
Acupuncture	Psychotherapy
Other:	

Please list any diagnostic tests which you have had (MRI, CT, EMG, etc.):

Test	Date	Test	Date
_____	_____	_____	_____
_____	_____	_____	_____

Social Profile

1. Age_____ Height _____ Weight _____
   What was your weight prior to the onset of your pain?_____
2. Highest grade level completed? _____
3. Current Martial status:
   Single _____ Divorced: _____ How many years ago? _____
   Married _____ How many years? _____ Widowed: _____ How many years ago? _____
4. Number of children_____ Number of children living at home _____ Age of children _____
5. Who do you live with? _____
6. Do you exercise? _____ How many times a week? _____
   What do you do?_____
7. Occupation: _____
8. Employment status:
   ____ Full time ____ Part-time ____ Homemaker ____ Retired ____ Disabled ____ Unemployed
9. If you are currently employed, please answer the following:
   a. Where do you work? _____
   b. Do you enjoy your work? ☐ Yes ☐ No
   c. Compared to your job performance before your present condition, how do you see your present abilities?
      _____ Can do as much as before _____ Can do somewhat less than before
      _____ Can do much less than before _____ Cannot do job at all
10. Are you currently involved in a lawsuit involving your pain? ☐Yes ☐No
11. Do you receive workman's compensation payments? ☐Yes ☐No
12. Do you receive disability payments? ☐Yes ☐No

Patient Label Here

13. Is there any chance that you are pregnant? ☐ Yes ☐ No ☐ N/A
14. Do you smoke? No _____ Yes _____ If yes, how much per day? _____
15. Do you use alcohol? No _____ Yes _____ If yes, do you do so under any of the following circumstances?
    _____ To help you relax
    _____ To help you sleep
    _____ To help relieve your pain
    _____ Only on social occasions
16. Have you ever had a DUI? _____ When? _____
17. Do you have a history of addiction or alcoholism? No _____ Yes _____ *If yes, please explain:* _____
18. Do you use "recreational" drugs? No _____ Yes _____ *If yes, what:* _____
19. Do you have any religious beliefs or practices that would affect our treating you? No _____ Yes _____
    If yes, please explain: _____

Thank you for filling out your North Fulton Pain Control Center questionnaire.

We will do our best to assist you in controlling your pain.

Reviewed by: _____RN Date: _____ Time:_____

The information provided in this form is true and complete to the best of my knowledge.

Patient signature _____

Updated (date) _____
_____

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