

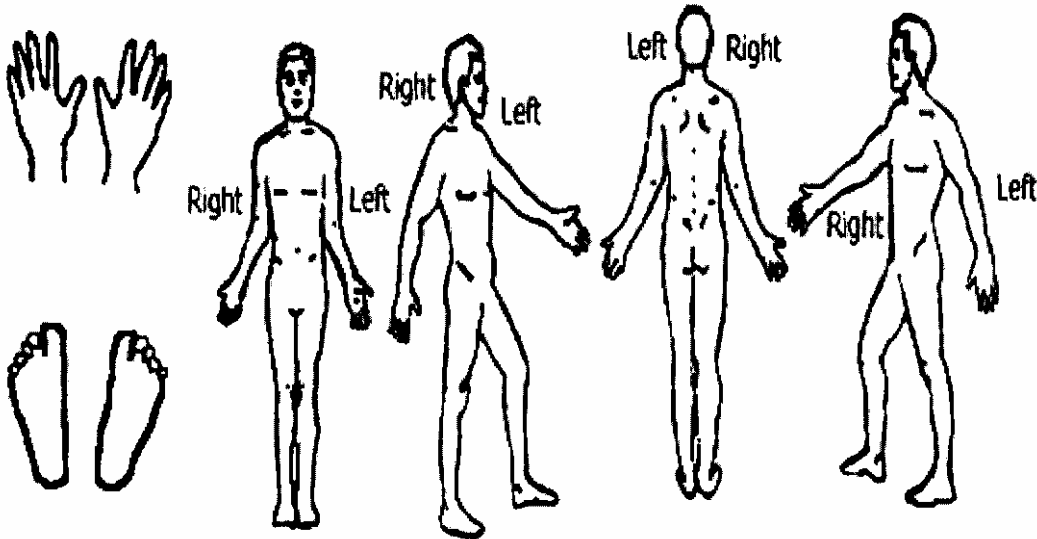


Lake County Pain Management, Ltd.

Patient Name: _____ Age: _____ Family Physician: _____

Height: _____ Weight: _____

Please mark you pain on the diagrams below:



Medical Staff Only
BP _____
P _____ R _____
SPO2 _____
Temp _____

On a scale of 0-10, 0 being no pain and 10 being the worst pain you have ever experience, please rate your pain:

At its best: _____ At its worst _____ How long have you had the problem? _____

How did your pain begin? (accident, illness, etc.):

Please circle any of the following symptoms that you are experiencing:

Is the problem: constant, intermittent, frequent, occasional, infrequent

Is the pain: sharp, dull, aching, throbbing, burning, tingling, shooting, stabbing, electrical

Is your problem: mild, moderate, severe, excruciating

What makes your pain worse? Please mark all that apply: Time of Day Weather

Moving affected limb Sitting Twisting Running Standing Bending Stairs

Walking Lying down Squatting Lifting Sexual activity

Other: _____

What are you doing to reduce your pain: Exercise/PT Lying down Ice Heat

Walking Avoiding Activity Medication Resting more often Massage

Lose Weight Sitting more Using a walker Other: _____

Do you have: Numbness or tingling? Yes No Muscle Weakness? Yes No

Swelling in the affected area? Yes No Muscle spasms or cramps? Yes No

Does your pain affect your:

- | | | | | | |
|-------------------|---------------------------|--------------------------|---------------|---------------------------|--------------------------|
| Sleep | <input type="radio"/> Yes | <input type="radio"/> No | Appetite | <input type="radio"/> Yes | <input type="radio"/> No |
| Physical activity | <input type="radio"/> Yes | <input type="radio"/> No | Emotions | <input type="radio"/> Yes | <input type="radio"/> No |
| Relationships | <input type="radio"/> Yes | <input type="radio"/> No | Concentration | <input type="radio"/> Yes | <input type="radio"/> No |
- Other: _____

Previous Treatments:

Treatment	Yes/No	How Helpful Was This?
Epidural Steroid/Nerve Block		
Surgery		
TENS Unit		
Physical/Occupational Therapy		
Chiropractic		
Biofeedback/Hypnosis		
Psychological Therapy		
Oral Steroids		
Non-steroidal Anti-inflammatory		
Other Pain Medications		

What are your GOALS for treatment?

If you are using or have used other pain medications, please list them here:

Review of Systems: Please check any that you currently have or have had in the past:

- | | | |
|--|--|--|
| Constitutional
<input type="checkbox"/> Recent fevers/sweats
<input type="checkbox"/> Unexplained weight loss/gain
<input type="checkbox"/> Unexplained fatigue/weakness | Musculoskeletal
<input type="checkbox"/> Muscle/joint pain
<input type="checkbox"/> Recent back pain
<input type="checkbox"/> Weakness | Skin
<input type="checkbox"/> Rash
<input type="checkbox"/> Sores |
| Blood/Lymphatic
<input type="checkbox"/> Easy bruising/bleeding
<input type="checkbox"/> Unexplained lumps | Gastrointestinal
<input type="checkbox"/> Constipation
<input type="checkbox"/> Nausea/vomiting/diarrhea | Neurological
<input type="checkbox"/> Headaches
<input type="checkbox"/> Numbness
<input type="checkbox"/> Tremors
<input type="checkbox"/> Poor balance |
| Ears/Nose/Throat/Mouth
<input type="checkbox"/> Difficulty hearing/ringing in ears
<input type="checkbox"/> Hay fever/allergies/congestion
<input type="checkbox"/> Trouble swallowing | Genitourinary
<input type="checkbox"/> Painful/bloody urination
<input type="checkbox"/> New onset of leaking urine
<input type="checkbox"/> Concern with sexual functions | Psychiatric
<input type="checkbox"/> Anxiety/stress
<input type="checkbox"/> Sleep problem
<input type="checkbox"/> Depression |
| Respiratory
<input type="checkbox"/> Coughing
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Asthma | Eyes
<input type="checkbox"/> Change in vision | Cardiovascular
<input type="checkbox"/> Chest pain/discomfort
<input type="checkbox"/> Palpitations/irregular heartbeat
<input type="checkbox"/> Shortness of breath |
- Have you had any recent infections? No Yes
- Are you taking antibiotics? No Yes

Medical History

Have you ever, or do you now have any of the following conditions?

- Heart Attack/Heart Disease
- Irregular Heart Rate
- Chest Pain/Angina
- High Blood Pressure
- Stomach/Intestinal Problems
- High Cholesterol
- Substance Abuse/Addiction
- Bleeding/Bruise Easily
- Emphysema
- Kidney problems/stones
- Thyroid Problems
- Diabetes
- Depression/Psych Issues
- Transient Ischemic Attack
- Cancer
- Stroke
- Asthma
- Epilepsy/Seizures
- Glaucoma
- Arthritis
- Other _____

List *any* surgeries you have had:

Type of Surgery	Date	Type of Surgery	Date

Please list *all* current medications and how often you take them:

Medication	Dose	Frequency	Medication	Dose	Frequency

Any known ALLERGIES?

ARE YOU ALLERGIC TO IODINE OR SHELLFISH? YES NO

Social History

Tobacco Use

Cigarettes: Never Quit: Date: _____ Current Smoker: packs/day _____ # of years _____
 Other Tobacco: Pipe Cigar Chew Snuff
 Are you interested in quitting? Yes No

Alcohol Use:

Do you drink alcohol? No Yes, # of drinks/week _____
 Is alcohol use a concern for you or others? No Yes

Drug Use

Do you use any recreation drugs? No Yes
 Have you ever used needles to inject drugs? No Yes

Occupational History

- Working full-time
- Working part-time
- On medical leave
- Disabled
- Unemployed

If working what is your current occupation? _____ How long? _____

Briefly, what duties do you perform? _____

When did you last work? _____

Litigation

Is Workers' Comp, disability, legal suit or an insurance settlement pending? No Yes, if yes
please describe:

If in litigation, please provide the name and phone number of your attorney: _____

Patient Signature: _____

Date: _____

Clinician Signature: _____

Date: _____