
Allayant Pain Management

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Name: _____ Date of Birth: _____ Age: _____

What doctor referred you here? _____ Appointment Date: _____

WHERE IS YOUR PAIN?

What is **usually** your **WORST** area of pain? _____

Left Right Middle Both sides

How often is **that area** painful? Constant Usual Frequent Occasional

PAIN ONSET & CHANGE

When did you first start having the pain that you are here for today? _____

What caused the pain to start?

Unkown Auto accident Work activity Home activity Other _____

How quickly did the pain start? Suddenly Gradually _____

Since the pain started, how has it changed? No change; stayed the same

Got worse gradually Got worse suddenly Improved over time

PAIN EVALUATION AND TESTING

What KINDS OF DOCTORS have evaluated or treated you?

- | | |
|--|--|
| <input type="checkbox"/> Primary care / family doctor | <input type="checkbox"/> Orthopedic surgeon |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Neurosurgeon |
| <input type="checkbox"/> Pain management specialist(s) | <input type="checkbox"/> Rheumatologist (arthritis doctor) |
| <input type="checkbox"/> Psychiatrist / Physical Medicine & Rehabilitation | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Osteopathic physician |

Have ANY of your previous doctors or clinics DISCHARGED you for any reason?

No

Yes – because _____

How long ago was this? _____

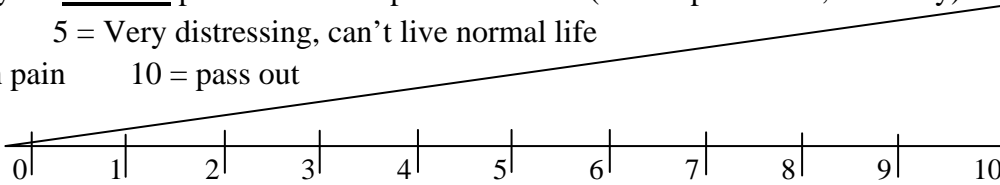
HOW BAD IS YOUR PAIN?

REVIEW THE PAIN EXAMPLES NEXT PAGE TO HELP DECIDE PAIN LEVEL
 Mark or circle the spot on the bottom line that is most like your pain level

How bad has your **USUAL** pain been in the past 1-2 weeks (WITH pain meds, if on any)?

0 = No pain 5 = Very distressing, can't live normal life

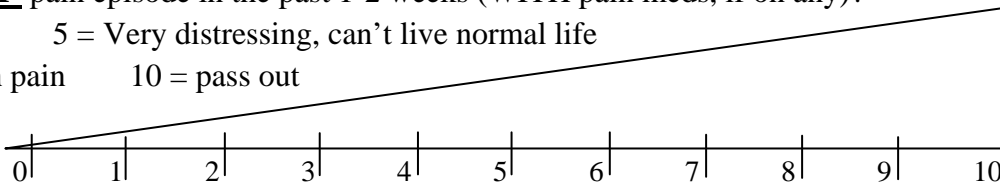
8 = Childbirth pain 10 = pass out



Your **WORST** pain episode in the past 1-2 weeks (WITH pain meds, if on any)?

0 = No pain 5 = Very distressing, can't live normal life

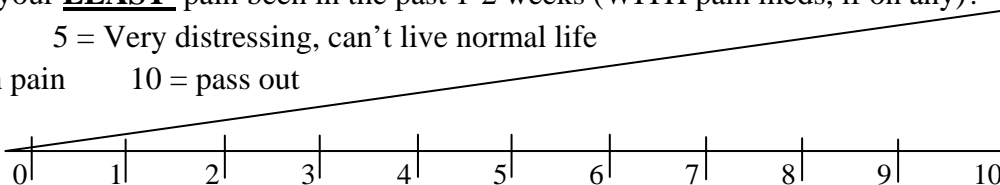
8 = Childbirth pain 10 = pass out



How bad has your **LEAST** pain been in the past 1-2 weeks (WITH pain meds, if on any)?

0 = No pain 5 = Very distressing, can't live normal life

8 = Childbirth pain 10 = pass out



Headaches	<i>If headaches are a major part of your pain, please answer these questions</i>
Location	<input type="checkbox"/> all over head <input type="checkbox"/> left side of head <input type="checkbox"/> right side of head <input type="checkbox"/> both sides of head <input type="checkbox"/> back of head <input type="checkbox"/> forehead <input type="checkbox"/> top of head <input type="checkbox"/> behind eye (left / right / both)
Frequency	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> 3-4 days/week <input type="checkbox"/> 2-3 days/week <input type="checkbox"/> 1 day/week <input type="checkbox"/> 2-3 times a month <input type="checkbox"/> 1 time a month <input type="checkbox"/> _____
Duration	<input type="checkbox"/> ___ days at a time <input type="checkbox"/> ___ hours at a time <input type="checkbox"/> ___ minutes at a time
Warning	Is there an "aura" that tells you before the headache it is coming? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If so, what is it? _____

PAIN SEVERITY DEFINITION AND EXAMPLES

Pain Type	Numbered Severity	Example Of Pain Cause
MINOR Does not interfere with most activity	1 -- Very Mild	Barely noticeable; Mosquito bite, poison ivy itch
	2 -- Discomfort	Minor pain, like lightly pinching the fold between thumb & 1 st finger using fingernails of the other hand
	3 -- Tolerable	VERY NOTICEABLE pain; like accidental cut; being hit in the nose causing bleeding; CAN get used to it
MODERATE Interferes with lots of life; Have to change activity to control pain	4 -- Distressing	Strong & deep, like toothache, first pain from bee sting; CAN'T get fully used to it
	5 -- Very distressing	Strong, deep, stabbing; like sprained ankle So bad NORMAL LIFE PREVENTED
	6 -- Intense	Strong, deep, stabbing so strong it distracts ALL the time. TROUBLE holding job or WITH NORMAL RELATIONSHIPS. Like bad headache, several bee stings, severe back pain
SEVERE Unable to keep normal activity. Disabled. Can't function without help	7 -- VERY Intense	Pain affects all your senses. Can ONLY THINK CLEARLY HALF the time. Can't live alone due to pain. Like bad migraine headache.
	8 -- Utterly Horrible	Pain so intense you CAN'T THINK CLEARLY AT ALL. May often think about suicide. Like CHILDBIRTH or VERY severe migraine.
	9 -- Excruciating, Unbearable	So severe you demand any medicine or surgery no matter the risk; if no treatment, PATIENT FREQUENTLY COMMITS SUICIDE; like advanced throat cancer
	10 -- Unimaginable, Unspeakable	Pain so intense you CAN'T STAY CONSCIOUS; quickly pass out. Like a severe accident such as a crushed hand, and losing consciousness

YOUR PAIN CONTROL (OK or NOT OK; with pain medicine, if any)

Is pain level OK MOST of the time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is pain level OK when you're INACTIVE / resting / relaxed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is pain level OK when you GET UP in the morning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is pain level OK when you try to SLEEP?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is pain level OK when doing normal ACTIVITIES?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WHAT YOUR PAIN IS LIKE; WHAT MAKES IT WORSE OR BETTER?

What words best describe your pain? *(Check all that apply)*

- | | | |
|--------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> aching | <input type="checkbox"/> stabbing | <input type="checkbox"/> burning |
| <input type="checkbox"/> squeezing | <input type="checkbox"/> throbbing | <input type="checkbox"/> sharp |
| <input type="checkbox"/> electrical | <input type="checkbox"/> gnawing | <input type="checkbox"/> shooting |
| <input type="checkbox"/> penetrating | <input type="checkbox"/> nagging | <input type="checkbox"/> exhausting |
| <input type="checkbox"/> tiring | <input type="checkbox"/> miserable | <input type="checkbox"/> unbearable |

What makes your pain worse? *(Check all that apply)*

- | | | | |
|--|--|------------------------------------|---------------------------------------|
| <input type="checkbox"/> bending | <input type="checkbox"/> standing | <input type="checkbox"/> walking | <input type="checkbox"/> sitting |
| <input type="checkbox"/> lifting | <input type="checkbox"/> reaching | <input type="checkbox"/> carrying | <input type="checkbox"/> touch |
| <input type="checkbox"/> driving | <input type="checkbox"/> cold | <input type="checkbox"/> hand use | <input type="checkbox"/> any activity |
| <input type="checkbox"/> stress, anxiety | <input type="checkbox"/> depression | <input type="checkbox"/> exercises | <input type="checkbox"/> lying down |
| <input type="checkbox"/> cough, sneeze | <input type="checkbox"/> strain for bowel movement | | <input type="checkbox"/> other: |

What makes your pain less or better? *(Check all that apply)*

- | | | | |
|---|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> position changes | <input type="checkbox"/> sitting | <input type="checkbox"/> walking | <input type="checkbox"/> stretching |
| <input type="checkbox"/> lying down | <input type="checkbox"/> heat | <input type="checkbox"/> cold | <input type="checkbox"/> rest |
| <input type="checkbox"/> sleep | <input type="checkbox"/> medication | <input type="checkbox"/> injections | <input type="checkbox"/> chiropractic |
| <input type="checkbox"/> massage | <input type="checkbox"/> brace / splint | <input type="checkbox"/> TENS / stim | |
| <input type="checkbox"/> other: | | | |

OTHER SYMPTOMS WITH YOUR PAIN:

Numbness or Tingling: NO NUMBNESS OR TINGLING

X	Numbness Location	How much / how often?		Comments
	Arm above elbow <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	
	Arm below elbow <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	
	Hand and fingers <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	
	Buttock <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	
	Thigh <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	
	Calf <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	
	Foot <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	

Weakness:		<input type="checkbox"/> NO WEAKNESS	
Weakness Location	How much / how often?	Comments	
Shoulder or arm <input type="checkbox"/> Left <input type="checkbox"/> Right	Weakness washing hair? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional
Forearm or elbow <input type="checkbox"/> Left <input type="checkbox"/> Right	Weakness lifting things? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional
Wrist or hand <input type="checkbox"/> Left <input type="checkbox"/> Right	Do you drop things? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional
Hip or thigh <input type="checkbox"/> Left <input type="checkbox"/> Right	Hard to stand from sitting? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional
Knee or leg below knee <input type="checkbox"/> Left <input type="checkbox"/> Right	Does your knee give way? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional
Ankle or foot <input type="checkbox"/> Left <input type="checkbox"/> Right	Does foot drag when walking? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional

YOUR CURRENT PHYSICAL FUNCTION:

Function:		<input type="checkbox"/> NO PROBLEM WITH ANYTHING	
Weakness Location	How much / how often?	Comments	
Standing at one time	_____ minutes		
Walking at one time	_____ minutes		
Sitting at one time	_____ minutes		
Sleep function	<input type="checkbox"/> Good <input type="checkbox"/> Fair to poor	<input type="checkbox"/> Fair to Good <input type="checkbox"/> Poor	<input type="checkbox"/> Fair
Bowel function	<input type="checkbox"/> Good <input type="checkbox"/> Fair to poor	<input type="checkbox"/> Fair to Good <input type="checkbox"/> Poor	<input type="checkbox"/> Fair
	<input type="checkbox"/> With diet alone <input type="checkbox"/> Prescribed laxative <input type="checkbox"/> Glycerin suppository	<input type="checkbox"/> Extra fiber <input type="checkbox"/> Over the counter laxative <input type="checkbox"/> With enemas	<input type="checkbox"/> Stool softener

WHAT PAIN AREAS OTHER THAN USUAL WORST PAIN ARE THERE?

Please mark each body area where you normally have pain **BAD ENOUGH TO LOOK FOR TREATMENT FOR IT**. Mark WHICH SIDE of the body has such pain. Mark HOW OFTEN you have such pain. Mark HOW LONG such pain lasts when it occurs.

Body Area & Side	How Often Is There Pain There		How Long Does Pain There Last	
Neck <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Upper back <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Mid back <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Shoulder <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Arm above elbow <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Elbow <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Forearm <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Wrist, hand, fingers <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Low back <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Abdomen, stomach <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Pelvis, groin <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Hip, buttock <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Thigh above knee <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Knee <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Leg below knee <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Ankle <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Foot, toes <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____
Other <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent	<input type="checkbox"/> Usual <input type="checkbox"/> Occasional	<input type="checkbox"/> Very brief <input type="checkbox"/> _____ hours	<input type="checkbox"/> _____ minutes <input type="checkbox"/> _____

WHAT PAIN EVALUATION & TREATMENT HAVE YOU HAD?

What TESTS have been done for your pain?		<input type="checkbox"/> None
Test	LAST done	Results
X-RAY TESTS:		
<input type="checkbox"/> XRay (what?)		
<input type="checkbox"/> XRay (what?)		
<input type="checkbox"/> CT scan (what?)		
<input type="checkbox"/> Bone scan		
<input type="checkbox"/> MRI neck		
<input type="checkbox"/> MRI low back		
<input type="checkbox"/> MRI _____		
<input type="checkbox"/> Myelogram / CT		
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		
LAB TESTS:		
<input type="checkbox"/> Rheumatology / arthritis tests		
<input type="checkbox"/> Vitamin D level		
<input type="checkbox"/> Vitamin B12 level		
<input type="checkbox"/> Folic acid level		
<input type="checkbox"/> Thyroid function tests		
<input type="checkbox"/> Testosterone level		
<input type="checkbox"/> Liver / hepatic function testing		
<input type="checkbox"/> Virus levels in blood		
<input type="checkbox"/> Delayed food allergies		
<input type="checkbox"/> Pregnancy test		
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		
OTHER TESTS:		
<input type="checkbox"/> Psychologist with testing		
<input type="checkbox"/> EMG / NCV's		
<input type="checkbox"/> When was your last EKG?		

What medication FOR PAIN have you tried BEFORE? None

Please check the box, as well as you can remember, for EACH MEDICINE TRIED BEFORE for your pain. Tell us why they were stopped, and what strength was used.

X	Medication	Daily Dose?	How Long Used?	Why did you stop this?	
	Tylenol with codeine			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Hydrocodone (Lortab, Lorcet, Vicodin)			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Ultram / Tramadol			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Percocet			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	OxyContin, Oxycodone			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Morphine: MS Contin, Kadian, Avinza, MSIR			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Dilaudid, Palladone			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Duragesic, Fentanyl			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Actiq, Fentora			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Opana, Oxymorphone			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Methadone			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Suboxone / Sebutex			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Buprenorphine			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Nucynta			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Elavil, amitriptyline			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Desipramine			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Pamelor, nortriptyline			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Desyrel, trazodone			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Sinequan, doxepin			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Effexor			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Lexapro			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Cymbalta			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Neurontin			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Gabitril			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Zonegran			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Topamax			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Lamictal			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Trileptal			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Tegretal			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Lyrica			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Keppra			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Depakote			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Savella			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	Virus medication			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects
	OTHER?			<input type="checkbox"/> didn't help	<input type="checkbox"/> side effects

What TREATMENTS have been tried for your pain (<i>other than meds</i>)?							<input type="checkbox"/> None
Treatment	Yes	No	LAST done	Better?	Worse?	No change?	How Long How many
THERAPY & EXERCISE							
Physical therapy							
Pool / water exercise therapy							
Brace or splint							
Stretching exercises							
Strengthening exercises							
Chiropractic care							
TENS unit / muscle stimulator							
Biofeedback							
Hypnosis							
INJECTIONS							
Trigger point injections (shots in the MUSCLES)							
EPIDURAL block low back (usually done under x-ray)							
EPIDURAL block neck (usually done under x-ray)							
Nerve block low back (usually done under x-ray)							
Nerve block neck (usually done under x-ray)							
Facet JOINT injection back (usually done under x-ray)							
Facet JOINT injection neck (usually done under x-ray)							
RADIO FREQUENCY RHIZOTOMY OR NERVE ABLATION							
RF killing of joint pain nerve in the back							
RF killing of joint pain nerve in the neck							
Other:							
OTHER TREATMENTS							
Antiviral medicine							
Vitamin D							
Vitamin B							
Vitamin E							
Calcium							
Magnesium							

Have you had any **SURGERY** done *for your pain?* [other surgery history comes later]

None recommended or done

Recommended but not done

Surgery	Year	Results

YOUR CURRENT OR MOST RECENT PAIN MEDICINE TREATMENT

What **MEDICATION FOR PAIN** are you **NOW** using **OR** most recently used?

Medication	Strength	How Prescribed?	How Used?	Last Prescription?

What **EXERCISES FOR PAIN** are you **NOW** doing? None

- Stretching How often? _____ Only when I hurt
- Strengthening How often? _____ What? _____
- Stabilizing How often? _____ What? _____
- Walking How often? _____ How many minutes at a time? _____
- Other: _____ How often? _____ How many minutes at a time? _____
- Other: _____ How often? _____ How many minutes at a time? _____

List medication **NOT PAIN RELATED** that you currently take: None

Medication	Medication

YOUR NON-PAIN MEDICAL HISTORY

ALLERGIES: Do you have any ALLERGIES (serious side effects)

None Allergy to: _____

INJURIES: Have you had any serious INJURIES requiring medical treatment (other than related to your current pain complaints)? Yes No If yes, how many times? _____

ACCIDENTS: Have you been in car accidents? Yes No If yes, how many times? _____

What doctors treat you currently for *NON-PAIN* health problems? None

- | | |
|---|---|
| <input type="checkbox"/> Primary care / family doctor | <input type="checkbox"/> Orthopedic surgeon |
| <input type="checkbox"/> Physiatrist / Physical Medicine & Rehabilitation | <input type="checkbox"/> Neurologist |
| <input type="checkbox"/> Rheumatologist (arthritis doctor) | <input type="checkbox"/> Neurosurgeon |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Addiction doctor | <input type="checkbox"/> OB / Gyn |

OTHER HEALTH PROBLEMS: (any ILLNESSES or diseases you have or had)

- | | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema / COPD |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> TB |
| <input type="checkbox"/> Reflux / GERD | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Crohns disease |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Interstitial cystitis | <input type="checkbox"/> Pelvic inflammatory disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Migraine headache |
| <input type="checkbox"/> Other headaches | <input type="checkbox"/> Chiari malformation |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bipolar syndrome | <input type="checkbox"/> Psychosis, schizophrenia |
| <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Use CPAP | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> ADD | <input type="checkbox"/> Post traumatic stress syndrome |

Have you had any surgeries OTHER THAN FOR PAIN? None

Surgery	Year	Results

FAMILY MEDICAL HISTORY

What medical problems have your close blood RELATIVES had? None Unknown

List:

Any blood relative with alcohol addiction now or in the past? Yes No

Any blood relative with drug addiction now or in the past? Yes No

Any blood relative with psychiatric treatment? Yes No

If so, what were they treated for? _____

TOBACCO, ALCOHOL AND CAFFEINE HABITS

Do you smoke? Yes: _____ cigarettes per day x _____ years No

Do you chew tobacco? Yes: _____ x _____ years No

How much beer, wine or other alcohol do you drink? None
 _____ per day **OR** _____ per week **OR** _____ per month

Have you ever been advised you were, or might be, an alcoholic?

Yes. If so, when? _____ No

Have you ever been in **alcohol** rehabilitation? No

Yes. If so, how many times? _____ Last time? _____

How many servings per day of caffeine do you usually use? None _____

RECREATIONAL DRUG HABITS

Have you in the past used any illegal / recreational drugs (marijuana, cocaine, heroin, etc.)?

Yes. If so, what and when last used? _____ No

Have you in the past used any benzos (Valium, Xanax, Ativan, etc.) not prescribed for you?

Yes. If so, what and when last used? _____ No

Have you ever been in **drug** rehabilitation? No

Yes. If so, how many times? _____ Last time? _____

CURRENT DRUG USE INCLUDING NARCOTICS NOT PRESCRIBED FOR YOU:

Please check whether or not you **NOW** use, or have used during the past **6 months**, any of the following which were **NOT PRESCRIBED** for you:

Drug	Yes	No	Drug	Yes	No
Amphetamines			Methamphetamines		
Marijuana			Cocaine		
Narcotic / opioid pain medicine			Anxiety medicine		
Heroin			Methadone		
Ecstasy			Downers		

Please tell us if you have been charged with any of the following, and explain: None

Possession of drugs with intent to sell – number of times, and what: _____

Misdemeanor charges & convictions – number of times, and what: _____

Felony charges & convictions – number of times, and what: _____

On probation or parole _____

THESE TWO QUESTIONS ARE VERY SENSITIVE, BUT VERY IMPORTANT TO HELP UNDERSTAND YOUR PAIN. REMEMBER, YOUR WHOLE RECORD IS CONFIDENTIAL

Have you ever been physically abused?

Yes No Age when abused? _____ Still abused How long? _____

Have you ever been sexually abused?

Yes No Age when abused? _____ Still abused How long? _____

Education / Employment / Career History:

How far did you finish in school? Elementary school High school
 Trade school College Professional school

Are you currently employed? Yes No

If so, what do you do? _____

Full time, or state hours / week: Full time _____ hours / week

If not, are you: retired since _____

disabled since _____

What was your last job / work? _____

When did you last work? _____

Have you been declared totally disabled? Yes No

Have you received a disability settlement? Yes No

REGULAR OR RECENT NON-PAIN SYMPTOMS (Please check any that apply)

General (Constitutional):		<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> chills	<input type="checkbox"/> fatigue	<input type="checkbox"/> fever
<input type="checkbox"/> night sweats	Unintended:	
<input type="checkbox"/> victim of domestic violence	<input type="checkbox"/> weight loss	<input type="checkbox"/> weight gain
Eyes:		<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> blurred vision	<input type="checkbox"/> eye pain	
<input type="checkbox"/> light sensitivity (<i>photophobia</i>)	<input type="checkbox"/> other _____	
Ears / Nose / Throat:		<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> ear pain	<input type="checkbox"/> decreased hearing	<input type="checkbox"/> tooth pain
<input type="checkbox"/> ringing ears (<i>tinnitus</i>)	<input type="checkbox"/> sore in nose not healing (<i>ulcer</i>)	
<input type="checkbox"/> stuffy nose (<i>congestion</i>)	<input type="checkbox"/> frequent nose drainage (<i>rhinorrhea</i>)	
<input type="checkbox"/> tooth pain	<input type="checkbox"/> dentures	<input type="checkbox"/> many teeth pulled

Heart & Blood Vessels (Cardiovascular)		<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> chest pain	<input type="checkbox"/> leg cramps when walking (<i>claudication</i>)	
<input type="checkbox"/> dizziness	<input type="checkbox"/> short of breath when lying down (<i>orthopnea</i>)	
<input type="checkbox"/> jumpy, irregular heart (<i>palpitations</i>)	<input type="checkbox"/> swelling feet / ankles (<i>pedal edema</i>)	
Lungs (Respiratory)		<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> RECENT cough	<input type="checkbox"/> long lasting cough (<i>chronic</i>)	
<input type="checkbox"/> dizziness	<input type="checkbox"/> easily short of breath (<i>dyspnea</i>)	
<input type="checkbox"/> exposure to TB	<input type="checkbox"/> coughing up blood (<i>hemoptysis</i>)	
Stomach & Bowels (Gastrointestinal)		<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> abdominal pain	<input type="checkbox"/> heartburn (<i>acid reflux</i>)	
<input type="checkbox"/> lack of eating (<i>anorexia</i>)	<input type="checkbox"/> trouble swallowing (<i>dysphagia</i>)	
<input type="checkbox"/> constipation	<input type="checkbox"/> diarrhea	
<input type="checkbox"/> black, tarry stools (<i>melena</i>)	<input type="checkbox"/> bloody stools (<i>hematochezia</i>)	
<input type="checkbox"/> nausea	<input type="checkbox"/> vomiting	
Urinary & Sexual (Genitourinary)		<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> painful menstruation (<i>dysmenorrhea</i>)	<input type="checkbox"/> painful urination (<i>dysuria</i>)	
<input type="checkbox"/> frequent urinary infections	<input type="checkbox"/> frequent urination	
<input type="checkbox"/> bloody urine (<i>hematuria</i>)	<input type="checkbox"/> loss of bladder control (incontinence)	
<input type="checkbox"/> history of rape	<input type="checkbox"/> history of sexual abuse	
<input type="checkbox"/> painful sexual intercourse (ladies: _____)	<input type="checkbox"/> painful penetration?	<input type="checkbox"/> painful positioning? _____
Muscles & Bones (Musculoskeletal)		<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> joint pains (<i>arthralgias</i>)	<input type="checkbox"/> back pain	
<input type="checkbox"/> joint stiffness	<input type="checkbox"/> pain in the limbs (arms or legs)	

Skin (Integumentary)	<input type="checkbox"/> None of these symptoms
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<input type="checkbox"/> extremely dry skin	<input type="checkbox"/> fungal infection of the nail
<input type="checkbox"/> itching skin	<input type="checkbox"/> yellowing of skin and eyes (<i>jaundice</i>)
Nervous System (Neurological)	<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> clumsiness in movement (<i>ataxia</i>)	<input type="checkbox"/> dizziness
<input type="checkbox"/> memory loss	<input type="checkbox"/> seizures
<input type="checkbox"/> numbness or sensory loss	<input type="checkbox"/> weakness
<input type="checkbox"/> headaches	<input type="checkbox"/> tremor
Blood & Lymph (Hematologic)	<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> easy bruising	<input type="checkbox"/> excessive bleeding
<input type="checkbox"/> history of blood transfusion	<input type="checkbox"/> swelling in any lymph nodes (<i>lymphadenopathy</i>)
Glands (Endocrine)	<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> heat or cold intolerance	<input type="checkbox"/> excessive thirst (<i>polydipsia</i>)
<input type="checkbox"/> excessive hunger (<i>polyphagia</i>)	<input type="checkbox"/> excessive sweating
Allergies & Immunity (Immunologic)	<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> frequent colds	<input type="checkbox"/> widespread itching
	<input type="checkbox"/> HIV infection
Psychiatric	<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> anxiety	<input type="checkbox"/> depression
<input type="checkbox"/> mood swings	<input type="checkbox"/> difficulty concentrating
<input type="checkbox"/> recreational drug use	<input type="checkbox"/> suicide thoughts
	<input type="checkbox"/> stress feelings
	<input type="checkbox"/> personality changes
	<input type="checkbox"/> suicide attempts _____
Sleep	<input type="checkbox"/> None of these symptoms
<input type="checkbox"/> trouble falling asleep: _____ nights a week (If so, how long does it take? _____)	
<input type="checkbox"/> trouble STAYING asleep: _____ nights a week	
How often do you wake up? _____ times / night	
How long to fall asleep again? _____	
Total hours / night you usually sleep: _____ hours a night	

Your goals for pain management

Please indicate what **YOUR** main goals are for pain management:

- | | | |
|---|---|--|
| <input type="checkbox"/> No pain | <input type="checkbox"/> Comfortable pain tolerance | <input type="checkbox"/> Tolerable pain |
| <input type="checkbox"/> Return to work | <input type="checkbox"/> Return to recreation | <input type="checkbox"/> Housework tolerance |
| <input type="checkbox"/> Improved sleep | <input type="checkbox"/> Other: _____ | |

What do you want to be able to do, how often, and how long, that would make you feel your pain control was good? _____

I hereby promise Dr. Bothe and Allayant Pain Management:

- | | | |
|--|------------------------------|-----------------------------|
| TO USE MY PAIN MEDICINE ONLY AS PRESCRIBED | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| TO STOP OR AVOID <u>ANY USE OF ALCOHOL</u> IF ON OPIOIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| TO USE NO MARIJUANA, COCAINE, METHAMPHETAMINES | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| TO USE NO PAIN MEDICINE OBTAINED FROM OTHER PEOPLE | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| TO REPORT ANY EMERGENCY VISIT WHERE MEDICINE IS GIVEN | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

My Signature: _____ **Date:** _____