Advanced Pain Control, Ltd.
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INITIAL VISIT PATIENT QUESTIONNAIRE

Patient Name: _____

Referred by: ☐ Physician ☐ Self ☐ Other: _____

Referring Physician:
Name: _____
Address: _____
Phone: _____

Primary Care Physician
Name: _____
Address: _____
Phone: _____

Case Manager:
Name: _____
Address: _____
Phone: _____

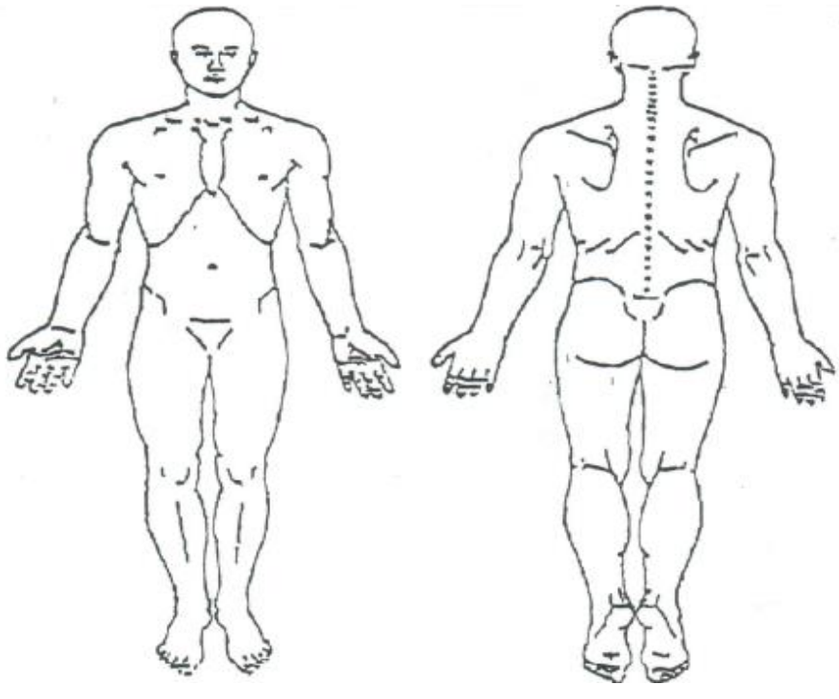
Attorney: (if involved in litigation regarding your pain)
Name: _____
Address: _____
Phone: _____

1) Please list all **diagnostic tests** performed for this condition.

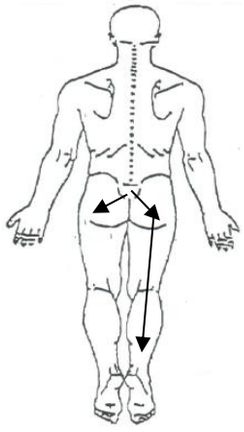
TEST	DATE	FACILITY
Plain X-rays		
CT Scan		
MRI Scan		
EMG		
Bone Scan		
Discogram		
Myelogram		
Other:		

2) Please indicate the location of the pain on the figure below:

RIGHT LEFT LEFT RIGHT



Example:



3) Where is the pain located for which you are seeking treatment: (example: back, neck, leg)

4) Where does the pain spread to? (example: leg, arm, hand)

5) Is your pain associated with ☐ numbness ☐ tingling ☐ weakness
If yes, where? _____

6) How old are you? _____ years old

7) What is the date of onset for your symptoms? _____ (date)

8) How were you injured or how did this pain **first start**?

- ☐ Sudden onset, no apparent cause
- ☐ Gradual onset, no apparent cause
- ☐ Lifting
- ☐ Twisting
- ☐ Fall
- ☐ Bending
- ☐ Pulling
- ☐ Injured at work
- ☐ Auto Accident
- ☐ Hit from behind
- ☐ Sports
- ☐ Other: _____

9) What **type of treatment** have you received?
Check all that apply.

- _____ Physical Therapy
- _____ Chiropractic treatment
- _____ Massage
- _____ Back brace
- _____ Anti-inflammatory medication
- _____ Muscle relaxant medication
- _____ Anti-depressant medication
- _____ Narcotic pain medication
- _____ Hot pack
- _____ Ice
- _____ TENS unit
- _____ Acupuncture
- _____ Biofeedback
- _____ Epidural steroid injections
- _____ Trigger point injections
- _____ Facet joint injections
- _____ Nerve blocks
- _____ Surgery
- _____ Other:_____

10) Check all words that **best describe** your symptoms:

- _____ Intermittent
- _____ Constant
- _____ Dull
- _____ Aching
- _____ Throbbing
- _____ Sharp
- _____ Shooting
- _____ Burning
- _____ Cramping
- _____ Nagging
- _____ Numbing
- _____ Radiating
- _____ Hypersensitive

If needed, list any other words that better describe your pain?

11) Check all situations that **worsen** your pain or symptoms:

- _____ General activity / exercise
- _____ Bending forward
- _____ Bending backward
- _____ Climbing stairs
- _____ Touching skin
- _____ Massage
- _____ Rest
- _____ Coughing
- _____ Standing
- _____ Sitting
- _____ Stretching
- _____ Stress / Tension
- _____ Sneezing
- _____ Night
- _____ Weather changes
- _____ Walking
- _____ Moving from sitting to standing

12) Check all that **decrease** your pain or symptoms:

_____ Lying down	_____ Applying ice
_____ Sitting	_____ Applying heat
_____ Walking	_____ Massage
	_____ Other: _____

13) Rate your pain on a scale ranging from **0** (no pain) to **10** (worst pain possible):

CURRENT pain: _____ / 10

BEST in last 30 days: _____ / 10

WORST in last 30 days: _____ / 10

14) Please list any **allergies** to medications: ☐ **NO KNOWN DRUG ALLERGIES**

ALLERGIES: _____

15) What medications have you tried in the past which have **NOT** successfully relieved your pain?
(example: Motrin, Tylenol, Darvocet, etc.)

16) **LIST ALL MEDICATIONS** you are presently taking: (include non-prescription and vitamins)
Including all pain medication.

Current Medications	Dose	How often do you take it?	How long?	Prescribing Doctor's Name

If more, please attach list to this questionnaire.

17) Do you have or have you had any of the following **medical conditions**?

Yes	No		Yes	No	
☐	☐	Arthritis	☐	☐	Hepatitis A / B / C
☐	☐	Bleeding disorder	☐	☐	HIV / AIDS
☐	☐	Bowel/Bladder problem	☐	☐	High Blood Pressure
☐	☐	Breathing problems/asthma	☐	☐	Joint problems
☐	☐	Cancer	☐	☐	Migraine headaches
☐	☐	Diabetes	☐	☐	Seizures
☐	☐	Depression	☐	☐	Sleep disturbance
☐	☐	Gout	☐	☐	Stomach / Intestinal problems
☐	☐	Head injury	☐	☐	Stroke / Neurological disease
☐	☐	Heart disease	☐	☐	Stomach ulcers

List any other medical problems: _____

_____

18) Please list all past **surgeries**. ☐ No past surgery.

Date	Type of Surgery

FAMILY HISTORY

19) Do any diseases run in your family?

Yes	No		Yes	No	
☐	☐	allergies	☐	☐	high blood pressure
☐	☐	arthritis	☐	☐	kidney disease
☐	☐	asthma	☐	☐	liver disease
☐	☐	blood disorder	☐	☐	lower back pain
☐	☐	cancer	☐	☐	lung disease
☐	☐	connective tissue disorder	☐	☐	osteoporosis
☐	☐	diabetes	☐	☐	seizures
☐	☐	epilepsy	☐	☐	stroke
☐	☐	gouty arthritis	☐	☐	stomach ulcer
☐	☐	heart disease	☐	☐	thyroid disease

SOCIAL HISTORY

20) What is your marital status?
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

21) Which is your dominant hand?
- ☐ Left
- ☐ Right
- ☐ Ambidextrous

22) Do you drink alcohol? ☐ No ☐ Occasionally ☐ Frequently

23) Do you smoke cigarettes?
- _____ No
- _____ Yes If yes: **1/4**, **1/2**, **1**, **2**, **3** packs per day

24) What is your current occupation? _____

REVIEW OF SYSTEMS

25) Do you have or have you had any of the following symptoms related to your present condition?

Weight loss	Yes _____	No _____
Weight gain	Yes _____	No _____
Fever / chills / night sweats	Yes _____	No _____
Dizziness	Yes _____	No _____
Nausea / Vomiting	Yes _____	No _____
Bruising	Yes _____	No _____
Asthma	Yes _____	No _____
Angina	Yes _____	No _____
Blood clots	Yes _____	No _____
Abdominal pain	Yes _____	No _____
Change in urinary / bowels habits	Yes _____	No _____
Difficulty sleeping	Yes _____	No _____
Back pain	Yes _____	No _____
Neck pain	Yes _____	No _____
Weakness or numbness in the arms or legs	Yes _____	No _____

Females only:

Is there any possibility you are **pregnant**? Yes _____ No _____

Last menstrual period date: _____