

MILLENNIUM PAIN CENTER

Personal Information:

Name _____ Date of Birth _____ Age _____

Address _____ City _____ Zip _____

S.S. # _____ Home Phone _____

Work Phone _____ Cell or Alternate Phone _____

Primary Physician _____ Referring Physician _____

Marital Status (circle one) S M W D

Employer _____ Occupation _____

Insurance Provider _____

Work Comp Case? Yes or No

Work Comp Case Worker's Name _____ Phone _____

Are you involved in a lawsuit? Yes or No

If yes, please explain: _____

Attorney's Name _____ Phone _____

Emergency Contact: _____ Relationship: _____

Phone: _____

How did you hear about Millennium Pain Center?

_____ Newspaper Advertisement

_____ Radio Advertisement

_____ Physician Referral

_____ Another Patient of Millennium Pain Center (name) _____

_____ Other (please explain) _____

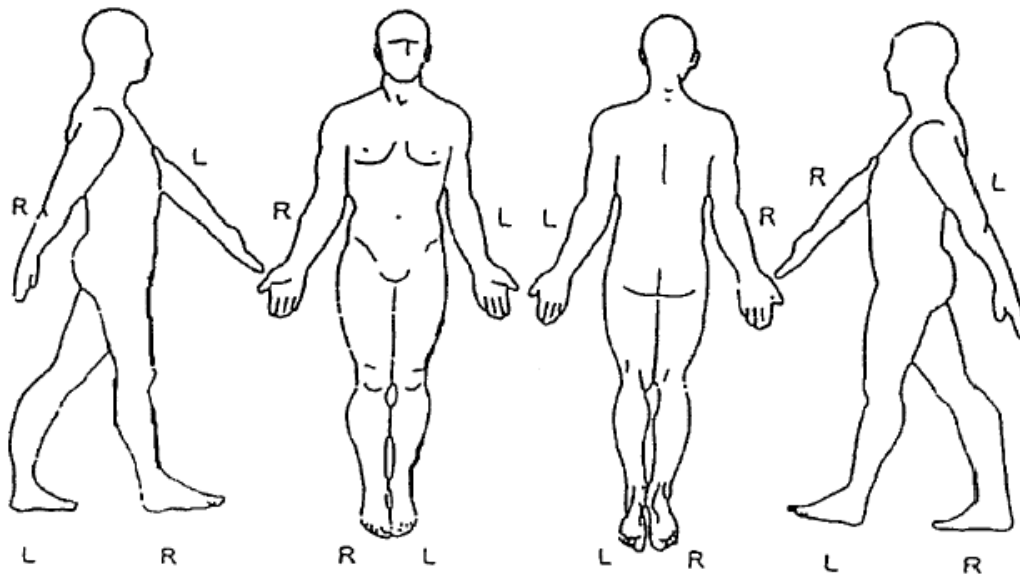
Medical History:

Check any that apply:

	You	Family		You	Family
Swallowing Difficulty			Hepatitis		
Gum Disease			Bowl Disorder		
Tonsillectomy			Kidney Disorder		
Thyroid Disease			Osteoarthritis		
Cataracts / Glaucoma			Rheumatoid Arthritis		
Asthma			Multiple Sclerosis		
Bronchitis			Stroke		
Emphysema			Epilepsy / Seizures		
Tuberculosis			Migraines		
Anemia			Head Injury		
Bleeding Disorders			Gout		
Heart Disease			Skin Disorder		
Heart Murmur			Anxiety		
Pacemaker			Depression		
High Blood Pressure					
Diabetes			Cancer Type: Treatment:		

Initial Pain Assessment

By answering the following questions, you will help your physician better understand and treat your pain. Please shade in all of the painful areas on the bodies provided.



General Health History

Are you allergic to anything (medication, food, or latex)? YES or NO

If yes, please list the allergy and the reaction:

Allergy	Reaction

Current Medications: include vitamins, over the counter meds, herbal meds, and prescribed meds.

NONE _____

Name of Medication	Dose	How often do you take it?

List any side effects you feel may be caused by your pain medication.

List your previous surgeries:

Previous Hospitalizations:

Substance Use:

Which of the following drugs or substances have you used in the **past?**

(Circle all that apply).

Alcohol _____	Barbiturates _____	Cocaine _____
Heroin _____	Amphetamines _____	Marijuana _____
Caffeine _____	Other _____	Other _____
(specify)	(specify)	(specify)

Next to each drug or substance that you've circled, indicate if you **used it** occasionally ("O"), frequently ("F"), or continuously ("C")

Are you **presently** using any of the drugs or substances below?

(Circle all that apply).

Alcohol _____	Barbiturates _____	Cocaine _____
Heroin _____	Amphetamines _____	Marijuana _____
Caffeine _____	Other _____	Other _____
(specify)	(specify)	(specify)

Next to each drug or substance that you've circled, indicate if you use it occasionally ("O"), frequently ("F"), or continuously ("C").

Do you smoke now? YES or NO Number of Packs per day _____

Have you ever smoked? YES or NO

If yes, how long did you smoke? _____ Number of Packs per day _____

Do you drink alcohol? YES or NO If yes, how much per day _____ week _____?

Do you take street drugs? YES or NO If yes, list: _____

Domestic Situation:

With whom do you live? _____

Are there any substance use issues in your household? YES or NO

If yes, please explain: _____

Are you able to care for yourself? YES or NO

If not, enter name of caregiver: _____

When and how did your pain problem start? (i.e., suddenly, gradually, or injured)

As far as you know, what is the cause of your pain (ie, the diagnosis)?

What doctors have you seen? When did you see them? What did they do?

Doctor's Name Month/Year Seen What was done for you?

Which is worse, leg or back pain? _____

Which position is worse, sitting, walking, or standing? _____

What tests have been done? (ie, MRI, CT-scan, X-Rays, etc.)

Tests and Studies Month/Year Done Results

What pain treatments or medications have received in the past? (For example, pain medications, physical therapy, acupuncture, TENS, etc.) Circle the number next to the treatment to signify the amount of pain relief that treatment provided.

Treatment or Medication **No Relief** **Complete Relief**

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

_____ 1 2 3 4 5 6 7 8 9 10

Which of these treatments or medications are you receiving right now?

What are your goals? (i.e. What do you expect to gain from your treatment)

Circle all of the words that describe your pain.

- | | | |
|--------------|------------|------------|
| Penetrating | Aching | Sharp |
| Nagging | Throbbing | Tender |
| Numb | Shooting | Burning |
| Tingling | Stabbing | Exhausting |
| Unbearable | Gnawing | Tiring |
| Intermittent | Continuous | |

Circle the number that best describes your pain at its **worst during the last month.**

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain imaginable

Circle the number that best describes your pain at its **least during the last month.**

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain imaginable

Circle the number that best describes your pain **on average during the last month.**

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain imaginable

Circle the number that best describes your pain as it is **right now.**

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain imaginable

Which of the following makes this pain feel ***better*** (circle all that apply):

Heat Ice Lying Down Rest Medication Leaning on Shopping Cart

Which of the following makes this pain feel ***worse*** (circle all that apply):

Walking Standing Sitting Coughing Sneezing Bending Forward Bending Backward

Circle the numbers below that best describe how pain has interfered with your daily functioning this past week.

0=Does not interfere 10=Completely interferes

General Activity	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Walking Ability	0	1	2	3	4	5	6	7	8	9	10
Normal Work Routine	0	1	2	3	4	5	6	7	8	9	10
Relations with Other People	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10
Ability to Concentrate	0	1	2	3	4	5	6	7	8	9	10
Appetite	0	1	2	3	4	5	6	7	8	9	10
Satisfactory Sexual Relationship	0	1	2	3	4	5	6	7	8	9	10

Do you have any of the following? (Please circle all that apply)

Headaches	Stomach Pain	Chest Pain	Dizziness
Insomnia	Nausea	Shortness of Breath	Vomiting
Difficulty Swallowing	Bladder Incontinence	Swollen Joints	Diarrhea
Constipation	Chronic Fatigue	General Malaise	Bowel Incontinence

Patient's signature _____ Date _____

Dr. _____ Date _____