

# OSF Millennium Pain Center

2200 Fort Jesse Road, Suite 210, Normal, IL 61761

Tel: (309) 661-6250 Fax: (309) 451-1378

## 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 \_\_\_\_\_

Is this a Workman's Comp case? Yes or No

If yes, Workman's 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: \_\_\_\_\_



**OSF**<sup>®</sup>

ST. JOSEPH MEDICAL CENTER

**Medical History:** Check all 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:		

**Functional Assessment**

What is the easiest way for you to learn new things?

- Reading    Listening    Pictures    Demonstration    Video

Do you have any difficulty with reading or writing?  No    Yes (explain) \_\_\_\_\_

Do you have any problems with any of the following?

- Vision    Hearing    Speech    Walking    Lifting

Do you have any religious or cultural beliefs/values we should be aware of as we provide your care?  No    Yes (explain) \_\_\_\_\_

Are you experiencing any stress/stressful situations?  No    Yes (explain) \_\_\_\_\_

Have you experienced any traumatic or abusive situations?  No    Yes (explain) \_\_\_\_\_



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

List your previous surgeries:

List your 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 _____ (specify)	Other _____ (specify)	Other _____ (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 _____ (specify)	Other _____ (specify)	Other _____ (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 \_\_\_\_\_ per 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?
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_____	_____	_____
_____	_____	_____

Which is worse: leg pain 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
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_____	_____	_____
_____	_____	_____
_____	_____	_____

What pain treatments or medications have you 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.

<b>Treatment or Medication</b>	<b>No Relief</b>	<b>Complete Relief</b>
_____	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=Did not interfere 10=Completely interfered

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

0=Did not interfere

10=Completely interfered

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 \_\_\_\_\_