MedStar Health

PATIENT LABEL

NEW PATIENT PAIN MANAGEMENT

Name: _____
First Middle Initial Last

Date of Birth: _____

Physician Background	
Referring Physician:	Phone #:
Office Address:	
Primary Care Physician:	Phone #:
Office Address:	
Pharmacy:	Phone #:
Address:	

Treatment History		
Have you ever been treated by another pain physician? ❑ Yes ❑ No		
Physician Name & Address	Phone #	Date Last Seen
Physician Name & Address	Phone #	Date Last Seen
Have you ever been discharged from a physician practice? ❑ Yes ❑ No If so, please explain.		
Have you ever had surgery intended to treat your current pain? ❑ Yes ❑ No		
Physician Name & Address	Phone #	Date Last Seen
Physician Name & Address	Phone #	Date Last Seen
Have you seen any other specialist related to your current pain? ❑ Yes ❑ No		
Physician Name & Address	Phone #	Date Last Seen
Physician Name & Address	Phone #	Date Last Seen

1. What is the main complaint for which you are seeking treatment?

2. How long have you had this pain issue?

3. What caused your pain?

Is the pain related to the following? ❑ Work Accident ❑ Auto Trauma ❑ Other Trauma :
Do you have a workers compensation claim, active or pending lawsuit related to your accident? ❑ Yes ❑ No
Current occupation or last job: _____ Did you stop work due to pain? ❑ Yes ❑ No

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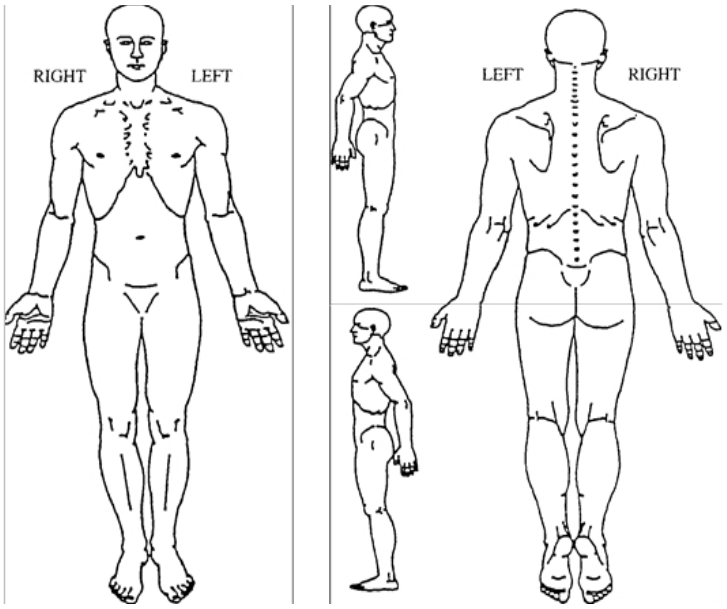
4. On the diagram, shade in the areas where you feel pain. Put an "X" on the area that hurts the most.



Where is your pain?

❑ Head ❑ Rt. Arm ❑ Rt. Low Back ❑ Lt. Leg

❑ Neck ❑ Hands ❑ Lt. Buttock ❑ Rt. Leg

❑ Lt. Shoulder ❑ Lt. Chest Wall ❑ Rt. Buttock ❑ Lt. Knee

❑ Rt. Shoulder ❑ Rt. Chest Wall ❑ Lt. Hips ❑ Rt. Knee

❑ Lt. Arm ❑ Lt. Low Back ❑ Rt. Hip ❑ Feet

Rate your current pain: (0=None 10=Extreme)

0 1 2 3 4 5 6 7 8 9 10

Rate your worst pain in the past month: (0=None 10=Extreme)

0 1 2 3 4 5 6 7 8 9 10

Rate your least pain in the past month: (0=None 10=Extreme)

0 1 2 3 4 5 6 7 8 9 10

Pain Description

How often do you have pain? ❑ Constant (80-100% of the time) ❑ Near Constant (50-80% of the time)
❑ Intermittent (25-50% of the time) ❑ Rare (less than 25% of the time)

Describe your current pain: (choose all that apply)

❑ Excruciating ❑ Intense ❑ Strong ❑ Severe ❑ Weak ❑ Agonizing ❑ Intolerable ❑ Unbearable ❑ Awful ❑ Miserable

❑ Distressing ❑ Unpleasant ❑ Uncomfortable ❑ Piercing ❑ Stabbing ❑ Sharp ❑ Shooting ❑ Burning ❑ Grinding ❑ Throbbing

❑ Cramping ❑ Aching ❑ Dull ❑ Stinging ❑ Squeezing ❑ Tingling ❑ Numbing

What makes pain better? (choose all that apply)

❑ Lying down ❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold ❑ Activity ❑ Massage ❑ Nothing

❑ Other: _____

What makes pain worse? (choose all that apply)

❑ Lying down ❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold ❑ Activity ❑ Stress ❑ Weather change

❑ Coughing/Sneezing ❑ Nothing ❑ Other: _____

In general, when is your pain the worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ No Typical Pattern

How many times during the day do you lie down because of the pain? _____

How many hours per day do you spend lying down because of the pain? _____

How many city blocks can you walk? _____ How many minutes can you sit? _____ or stand? _____

Have you missed time from work? ❑ Yes ❑ No Have you decreased social activities? ❑ Yes ❑ No

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Patient Safety Screen	
Preferred Language: ❑ English ❑ Spanish ❑ Other _____	
Communication Needs: ❑ None ❑ Sign interpreter needed ❑ I will bring a sign interpreter	
Barriers to learning: ❑ Difficulty reading ❑ Vision Impairment ❑ Hearing Impairment ❑ Learning disorder	
Religious Preference: ❑ Catholic ❑ Christianity ❑ Judaism ❑ Islam ❑ Buddhism ❑ Hinduism ❑ Jehovah's Witness	
Advance Directives: ❑ Written information provided ❑ Written information declined ❑ On file	
Caregiver at home: ❑ No ❑ Yes Name of Caregiver:_____	
Caffeine (coffe, tea, cola, etc.) intake per day: _____ **Nicotine (cigarettes, cigar, pipe, smokeless tobacco, etc) intake per day :** _____	
Concerned with falling? ❑ Yes ❑ No ❑ No falls in the past year ❑ One fall in the past year ❑ Two or more falls last year ❑ Recent fall	
Assistive Device: ❑ None ❑ Cane ❑ Crutches ❑ Walker ❑ Wheelchair ❑ Motorized chair ❑ Stretcher **Activities of Daily Living:** ❑ ADL- independent ❑ ADL-assisted	
In the past two weeks: Little interest/pleasure doing things: ❑ None ❑ Several days ❑ A week ❑ Nearly every day **In the past two weeks:** Feeling down/depressed/hopeless: ❑ None ❑ Several days ❑ A week ❑ Nearly every day	
Your present use of alcoholic beverages is (choose one): ❑ Rarely ❑ Socially ❑ Regularly _____ drinks/day Have you ever felt you needed to cut down on your drinking? ❑ Yes ❑ No Have people annoyed you by criticizing your drinking? ❑ Yes ❑ No Have you ever felt guilty about your drinking? ❑ Yes ❑ No Have you ever needed a drink first thing in the morning to steady your nerves or get rid of a hangover? ❑ Yes ❑ No	
Have you ever used any of the following drugs? (choose all that apply) ❑ Marijuana ❑ Cocaine ❑ Other Street Drugs ❑ Amphetamines ❑ Heroin ❑ None of these	
Does your pain wake you from sleep during the night? ❑ Usually ❑ Sometimes ❑ Never How many hours do you sleep nightly? _____	
Do you feel rested during the day? ❑ Yes ❑ No	Are you able to take care of your personal hygiene? ❑ Yes ❑ No
Are you able to drive? ❑ Yes ❑ No	Are you able to do household chores/ meal prep? ❑ Yes ❑ No
Have you ever tried to hurt yourself or commit suicide? ❑ Yes ❑ No Describe _____	
Do you presently have any thoughts of harming or hurting yourself or anyone else? ❑ Yes ❑ No Describe _____	
Have you ever been treated by a psychiatrist, a psychologist, other mental health professionals? ❑ Yes ❑ No Describe _____	
Did any of the above include in-patient treatment? ❑ Yes ❑ No Describe _____	
Goals for managing your pain: ❑ Complete Pain Relief ❑ Increased Job Activities ❑ Reduced Medication ❑ Partial Pain Relief ❑ Increased General Activities ❑ Other: _____	

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Past Medical History *(more space provided on back)*			
❑ Hypertension	❑ COPD/Emphysema	❑ Seizure Disorder	❑ Rheumatoid Arthritis
❑ Heart Disease	❑ Asthma	❑ Migaine Headaches	❑ Osteoarthritis
❑ Abnormal Heart Rhythm	❑ Heartburn/GERD	❑ Multiple Sclerosis	❑ Osteoporosis
❑ Pacemaker Implant	❑ Sleep Apnea	❑ Peripheral Neuropathy	❑ Cancer
❑ Stroke	❑ Stomach Ulcers	❑ Kidney Disease	❑ Bipolar Disorder
❑ Bleeding Disorder	❑ GI Bleed	❑ Glaucoma	❑ Depression
❑ Liver Disease	❑ Blood Clots	❑ Drug Addiction	❑ Anxiety
❑ Alcoholism	❑ Diabetes Type I/II	❑ HIV/AIDS	❑ Fibromyalgia
❑ Vascular Disease	❑ Hypo/Hyperthyroid	❑ Hepatitis C	❑ IBS
Other Conditions not listed above:			

Past Surgical History *(more space provided on back)*		
Surgery	Date (month/year)	Doctor

Current Medications *(more space provided on back)*		
Drug	Dose	Frequency

Allergies *(more space provided on back)*	
Drug	Reaction

Family History			
Relationship	Medical Condition	Relationship	Medical Condition
Mother		Father	
Sister		Brother	
Daughter		Son	
Other:		Please check here if adopted ❑	

Review of Systems			
Constitutional: ❑ Fevers ❑ Chills, ❑ Night sweats ❑ Weight loss ❑ Fatigue/Weakness	**Eye:** ❑ Change of vision ❑ Eye pain ❑ Visual problems ❑ Diplopia ❑ Blurry vision	**Ear, Nose, Throat:** ❑ Ear pain ❑ Nasal congestion ❑ Sore throat ❑ Decreased hearing	**Respiratory:** ❑ Shortness of breath ❑ Cough ❑ Wheezing
Cardiovascular: ❑ Chest pain ❑ Pressure ❑ Palpitations ❑ Syncope ❑ Loss of consciousness ❑ Edema	**Gastrointestinal:** ❑ Change in bowel habits ❑ Nausea, ❑ Vomiting ❑ Diarrhea ❑ Constipation ❑ Melena ❑ Anorexia	**Genitourinary:** ❑ Hematuria ❑ Nocturia ❑ Discharge ❑ Dysuria ❑ Incontinence ❑ Urinary frequency ❑ Urinary retention	**Endocrine:** ❑ Increased thirst ❑ Swollen lymph glands ❑ Bruising tendency ❑ Change in appetite ❑ Heat intolerance ❑ Cold intolerance

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Review of Systems *(continued)*

Musculoskeletal:	**Integumentary:**	**Neurologic:**	**Psychiatric:**
❑ Back pain	❑ Rash	❑ Headache	❑ Anxiety
❑ Neck pain	❑ Pruritus	❑ Paresthesia	❑ Depression
❑ Joint pain	❑ Abrasions	❑ Limb weakness	❑ Suicidal ideation
❑ Muscle pain		❑ Dizziness/Vertigo	❑ Phobia
❑ Swelling		❑ Seizures	❑ Paranoia
❑ Change in ROM		❑ Numbness	❑ Hallucinations
		❑ Memory Problems	

Treatment History

Have you tried any listed medications to alleviate your pain?

❑ Acetaminophen/Tylenol	❑ Pregabalin/Lyrica	❑ Cyclobenzaprine/Flexeril	❑ Morphine/MsContin
❑ Aspirin/Bayer	❑ Neurontin/Gabapentin	❑ Metaxalone/Skelaxin	❑ Hydrocodone/Vicodin
❑ Ibuprofen/Motrin	❑ Topiramate/Topamax	❑ Tizanidine/Zanaflex	❑ Oxycodone/Oxycontin
❑ Naproxen/Aleve	❑ Carbamazepine/Tegretol	❑ Methocarbamol/Robaxin	❑ Hydromorphone/Dilaudid
❑ Ketorolac/Toradol	❑ Oxcarbazepine/Trileptal	❑ Baclofen/Lioresal	❑ Oxymorphone/Opana
❑ Diclofenac/Voltaren	❑ Duloxetine/Cymbalta	❑ Carisoprodol/Soma	❑ Tramadol/Ultram
❑ Meloxicam/Mobic	❑ Amitriptyline/Elavil	❑ Diazepam/Valium	❑ Tapentadol/Nucynta
❑ Nabumetone/Relafen	❑ Nortriptyline/Pamelor	❑ Sertraline/Zoloft	❑ Fentanyl/Duragesic
❑ Etodolac/Lodine	❑ Milnacipran/Savella	❑ Paroxetine/Paxil	❑ Methadone/Dolophine
❑ Celecoxib/Celebrex	❑ Lidocaine Ointment	❑ Bupropion/Wellbutrin	❑ Buprenoprhine/Suboxone

Have you ever tried any listed treatments to alleviate your pain?

❑ Acupuncture	❑ Massage	❑ Aquatherapy	❑ Sacroiliac Injections
❑ Biofeedback	❑ Hospital Bed Rest	❑ Physical Therapy(see below)	❑ Spinal Cord Stimulation
❑ Chiropractor	❑ TENS(Electrical Stimulation)	❑ Epidural Steroid Injections	❑ Intrathecal Pump
❑ Hot/Cold treatments	❑ Ultrasound	❑ Facet Injections	❑ Other:
❑ Traction	❑ Psychotherapy	❑ Sacroiliac Injections	

Physical Therapy: Name of facility _____

How Long _____. Dates_____

Have you modified your activities for at least 6 weeks to help with your pain? ❑ Yes ❑ No

Did it help? ❑ Yes ❑ No

Family History of Substance Abuse

Alcohol ❑ Yes ❑ No Illegal Drugs ❑ Yes ❑ No Prescription Drugs ❑ Yes ❑ No

Personal History of Substance Abuse

Alcohol ❑ Yes ❑ No Illegal Drugs ❑ Yes ❑ No Prescription Drugs ❑ Yes ❑ No

Age (Mark box if 16 - 45) ❑ Yes ❑ No

Psychological Disease

Attention Deficit Disorder ❑ Yes ❑ No Obsessive Compulsive Disorder ❑ Yes ❑ No

Bipolar Disorder ❑ Yes ❑ No Schizophrenia ❑ Yes ❑ No

Depression ❑ Yes ❑ No

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Please continue writing here if more space is needed:

Signature of Patient: _____

If form has been completed by someone other than the patient, please print name and sign below:

Name: _____

Signature: _____

Relationship to Patient: _____