Sunrise Medical GROUP, P.C.

Patient Information

Today's date: _____

Your name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

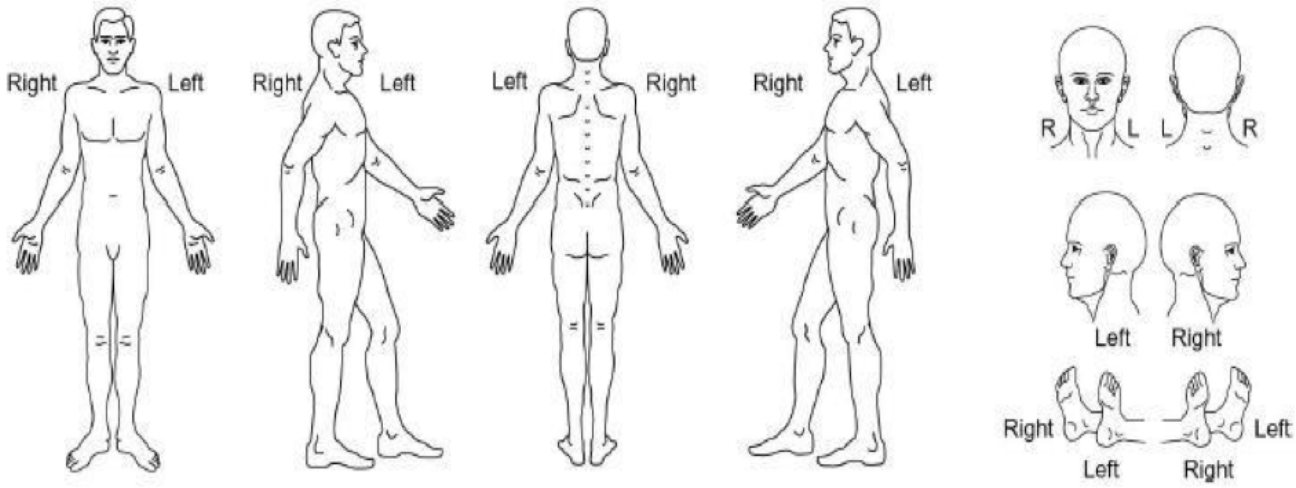
Pain History

Chief Complaint (Reason for your visit today): _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

Use the diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately when did the pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? ▢ Gradually ▢ Suddenly

Since your pain began, how has it changed? ▢ Improved ▢ Worsened ▢ Stayed the same

Pain Description

Describe the character of your pain (eg. dull, stabbing, throbbing, etc):

_____

What time of day is your pain at its worst? _____

How often does the pain occur?

▢ Constant ▢ Changes in severity but always present ▢ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now _____ The Best It gets _____ The Worst It Gets _____

What other factors worsen or affect of your pain?

_____

What other factors relieve your pain?

_____

Are there any associated symptoms? (eg. numbness/tingling/weakness/incontinence, etc)

_____

What are the goals you wish to achieve with Pain Management?_____

_____

Diagnostic Tests and Imaging

Mark the following tests that you have had, related to your current pain complaints:

▢ MRI of the: _____ Date: _____

▢ X-Ray of the:_____ Date: _____

▢ CT Scan of the: _____ Date: _____

▢ EMG/NCV study of the: _____ Date: _____

▢ Other Diagnostic Testing: _____ Date: _____

▢ I have not had ANY diagnostic tests for my current pain complaint

Please mark all of the following treatments you have had for pain relief:

	No change	Worsened Pain	Helped Pain
Spine Surgery	▢	▢	▢
Physical Therapy	▢	▢	▢
Chiropractic Care	▢	▢	▢
Psychological Therapy	▢	▢	▢
Brace Support	▢	▢	▢
Acupuncture	▢	▢	▢
Hot/Cold Packs	▢	▢	▢
Massage therapy	▢	▢	▢
TENS Unit	▢	▢	▢

Interventional Pain Treatment History

▢ Epidural Steroid Injection - (Circle all levels that apply): Cervical/ Thoracic/ Lumbar

▢ Joint Injection - Joint(s) _____

▢ Medial Branch Blocks/ Facet Injections - (Circle levels): Cervical/ Thoracic/ Lumbar

▢ Nerve Blocks - Area/Nerve(s) _____

▢ Radiofrequency Nerve Ablation - (Circle levels): Cervical/ Thoracic/ Lumbar

▢ Spinal Cord Stimulator - Trial Only/Permanent Implant _____

▢ Trigger Point Injections - Where? _____

▢ Vertebroplasty/Kyphoplasty - Level(s) _____

▢ Other - _____

Which of these procedures listed above have helped you with your pain? _____

_____

Please list the names of other Pain Physicians you have seen in the past:

_____

Mark the following physicians or specialists you have consulted for you current pain:

▢ Acupuncturist Provider: _____

▢ Neurosurgeon Provider: _____

▢ Psychiatrist/ Psychologist Provider: _____

▢ Chiropractor Provider: _____

▢ Orthopedic Surgeon Provider: _____

▢ Rheumatologist Provider: _____

▢ Internist Provider: _____

▢ Physical Therapist Provider: _____

▢ Neurologist Provider: _____

▢ Other _____

Current Medications

Are you currently taking any blood thinners or anti-coagulans? ▢ Yes ▢ No

If YES, which ones? ▢ Aspirin ▢ Plavix ▢ Coumadin ▢ Lovenox ▢ Other _____

Please list all medications you are currently taking including vitamins & supplements (as an example, Saw Palmetto, St. John's Wort, etc).

On average, how often do you have a bowel movement? Please check one.

▢ More than 3 times per day ▢ 2-3 times per day ▢ Once per day

▢ 2-3 times per week ▢ Less than once per week

Think back to when you started pain medicine. Did your bowel habits change? If so, how?

_____