

\* Last Name

\* First Name  Middle Initial

\* Address

\* City

\* State  **Because of individual state law we are unable to prescribe in the following states: NV, OR, AZ, KS, AR and MO.**

\* Zip

\* E-mail Address

\* Home Phone

\* Best Time to Call:

\* Work Phone

\* Best Time to Call:

\* Referred By:  \*

\* How did you hear of us?  \*

If you were referred to us by a friend or another clinic, please tell our Patient Coordinator when she calls. ([referral offer details found here](#))

\* SSN  \* DOB  \* Gender

\* Height  ( Feet/Inches ) \* Weight  ( US Standard Pounds )

\* Do You Have Any Allergies?

If You have Any Allergies list them here:

List any medications you are allergic to or do not tolerate.

Provide the name, address, and telephone number of the person who is closest to you-- spouse, parent, child, or companion.

\* Companions Name:

\* Companion Address:

\* Companion Phone:

\* Companion Relationship:

\* **Diagnosis**  
description of your pain.

Describe when and how the pain problems identified above began and progressed.

\* Provide the name, telephone, and fax numbers of your current local Primary Care Physician.

Primary Care Physician Name:

Primary Care Physician Address:

Primary Care Physician Phone:

Primary Care Physician Fax:

The characteristics of your pain.

\* Check all that apply.

	Yes	No
Sharp	<input type="checkbox"/>	<input type="checkbox"/>
Dull	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Aching	<input type="checkbox"/>	<input type="checkbox"/>
Stabbing	<input type="checkbox"/>	<input type="checkbox"/>
Shooting	<input type="checkbox"/>	<input type="checkbox"/>
Throbbing	<input type="checkbox"/>	<input type="checkbox"/>
Cramping	<input type="checkbox"/>	<input type="checkbox"/>
Electric	<input type="checkbox"/>	<input type="checkbox"/>
Localized	<input type="checkbox"/>	<input type="checkbox"/>
Intermittent	<input type="checkbox"/>	<input type="checkbox"/>
Steady	<input type="checkbox"/>	<input type="checkbox"/>

Please rate your symptoms on a scale of 1 to 10

Current Pain Level?

Average Pain Level?

Worst Pain Level last week?

Best Pain Level last week?

Comments about pain levels:

If your pain is intermittent, what brings it on?  
How long does it last? How often does it recur?

Superficial	<input type="checkbox"/>	<input type="checkbox"/>
Deep	<input type="checkbox"/>	<input type="checkbox"/>
Diffuse	<input type="checkbox"/>	<input type="checkbox"/>

**Describe the way your pain interferes with work or activities of daily living.**

**Prior Evaluation and Treatment**

Please provide the name, address, and telephone of the clinic or physician who treated or evaluated you most recently.

Physician Name:

Physician Address:

Physician Phone:

Physician Specialty:

**List any tests or procedures you underwent to diagnose your pain.**

**List the surgical procedures you underwent to treat your pain.**

**List the non-surgical procedures you underwent related to your pain problem and whether you obtained any benefit (such as Physical Therapy, TENS, Bio-feedback, etc.).**

**List any medications you have tried for pain control, the dose you took, and whether you obtained any benefit or had any adverse reactions.**

Name	Dose	Frequency	Effect

Have you ever been treated for any of the following conditions?

	Yes	No
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
HIV/Aids	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/COPD	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>

List any other chronic or recurrent medical problems from which you suffer or have suffered in the past (other than the pain problem described above).

**Please Note:**

The information being collected here is to protect you and help our doctor properly evaluate your needs. It's not possible for us to ask every combination of specific questions to cover every potential patient.

Deliberate omitting of important facts can lead to interruption of service later.

List all medications you currently take, whether for pain control or other medical conditions, the dose, and the frequency.

Name	Dose	Frequency	Reason

What medications are you requesting?

How long have you been using these medications?

How many doctors have recommended them?

How many doctors have refused to prescribe them?

Compared to when you started how much medication do you now use?

How effective are these medications in helping the problems at this time?

To what extent do you feel doctors understand your need for medications?

How concerned are you about becoming dependent or addicted?

How long can you go without these medications?

How long do you believe you will need to use these medications?

CHECK ANY ITEMS THAT APPLY TO YOU PRESENTLY OR IN THE PAST

1 - Yes  No  When I use prescription drugs I am in a better mood.

2 - Yes  No  I have used prescription drugs for other than medical reasons.

- 3 - Yes  No  When I was younger I experimented with illegal drugs.
- 4 - Yes  No  I feel more comfortable when I can stockpile my prescription drugs.
- 5 - Yes  No  I often take prescription drugs more often than instructed.
- 6 - Yes  No  I believe I may be dependent upon prescription drugs.
- 7 - Yes  No  I've filled the same prescription from different doctors at the same time.
- 8 - Yes  No  I tend to use more prescription drugs when I am under stress.
- 9 - Yes  No  I have used other people's prescription drugs.
- 10 - Yes  No  My family and friends worry about how much I use prescription drugs.
- 11 - Yes  No  My use of prescription drugs has cause problems with my family or work.
- 12 - Yes  No  I can think of little else if I do not have my medications.
- 13 - Yes  No  I do not think I can get along without drugs.
- 14 - Yes  No  I have used illegal methods to obtain prescription drugs.
- 15 - Yes  No  I have been arrested as a result of prescription drugs.
- 16 - Yes  No  Even though I try I cannot stop using prescription drugs.
- 17 - Yes  No  Prescription drugs other than the ones I use do not seem to work.
- 18 - Yes  No  I have blacked out or lost track of time while on prescription drugs.
- 19 - Yes  No  I have spent money on prescription drugs which I probably didn't need.
- 20 - Yes  No  Without my prescription drugs I experience withdrawal symptoms.
- 21 - Yes  No  If I could no longer get my prescription drugs I could become suicidal.
- 22 - Yes  No  I find myself using alcohol if I do not have my prescription drugs.
- 23 - Yes  No  Using prescription drugs has caused me to have other medical problems.
- 24 - Yes  No  I have considered or sought treatment for prescription drug abuse.

Have you ever had any of the following conditions?

	Yes	No
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar (Manic-Depressive) Illness	<input type="checkbox"/>	<input type="checkbox"/>
Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>
Phobias	<input type="checkbox"/>	<input type="checkbox"/>

If you have recently been under the care of a psychologist or psychiatrist, please provide his or her name, address, and telephone number below.

Name:

Address:

Phone:

Suicide Attempts	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Physical/Sexual Abuse as a child	<input type="checkbox"/>	<input type="checkbox"/>

List any other psychiatric problems from which you suffer or have suffered in the past.

List any medications you currently take for any psychiatric condition or symptom.

Name Dose Frequency Reason

Name	Dose	Frequency	Reason

Has your pain or its treatment disrupted your relationship with members of your family or household? Describe.

Have you ever used the following substances?

	Yes	No	Year of Last Use
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 40px;" type="text"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 40px;" type="text"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 40px;" type="text"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 40px;" type="text"/>
Alcohol to Excess	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 40px;" type="text"/>
Other <input style="width: 100px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 40px;" type="text"/>

If you've ever been treated for drug or alcohol abuse, please indicate:

A. When you were in treatment.

B. Where you received treatment:

Name:   
 Address:   
 Phone:

Have you used a methadone drug treatment program to obtain medication for pain control?

If you have had any legal problems relating to the use of drugs, alcohol, or medications, please list the year and describe the circumstances.

**Education and Employment**

- A. Highest level of education.
- B. Professional Training.
- C. Most recent or current employment.
- D. How long were you employed in your last position?
- E. Current Employment Status

Living arrangements

Marital status.

Do you drive?

Any accidents or traffic violations while driving under the influence of medications or alcohol?

Are you involved in litigation relating to your medical condition?