

Name:

Diagnosis description of your pain:

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

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

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

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

List any medications you have tried

pain problem and whether you obtained any benefit (such as Physical Therapy, TENS, Bio-feedback, etc.).

for pain control, the dose you took, and whether you obtained any benefit or had any adverse reactions.

Name	Dose	Frequency	Effect
<input type="text"/>			

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).

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

Name	Dose	Frequency	Reason
<input type="text"/>			

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.

What medication are you requesting?

How long have you been using this 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?

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