Pain Questionnaire & Medical History **Dayton Pain Center, LLC / Dayton**

Patient Name: _____ DOB: ____/____/19____ Date____/____/2012

Referring Physician: _____ Primary care Physician: _____

Circle and use check marks when appropriate. Down loading and proper filling it prior to coming to the office visit will save you waiting time. You will not be seen with out completed forms.

I: **Chief Complaint**(s)**:** Describe in your words where it is? what pain is like, How it feels? **When and how** did your problem first started (accident, injury etc?) Describe each area of pain separately. If BWC, describe the first injury in detail & job title and duty.

1_____

_____

2_____

_____

3_____

_____

HPI: Severity of pain level Location: (In a scale of 0 - 10 per body part. 0 being no pain, 10 being worst pain in your life)

Head _____ Face:_____ Neck:_____Thorax:_____ Lumbar:_____ Lumbo-sacral:_____

Extremities: Upper: R _____ L_____ Lower: R_____L_____ Chest:_____ Abdomen:_____Other_____

Joints: Shoulder:_____Elbow:_____wrist:_____Hip:_____Knee:_____Ankle:_____Other_____

4. Does your pain radiate: Yes to_____No

5. How long? Is it constant? Does it come and go?_____

6. How many hours you sleep? _____ Do you toss & turn?: Yes / No Does Pain Wakes you Up?: Yes / No

7. Have you seen any other Pain Physician(s)/Chiropractic physician:Yes_____No

8: What type of injections you have? Bywhom?_____

9. Pain level without medications (0-10): _____ Pain level with medications (0-10): _____

10. Using the pain scale of 0-10 Please rate what your **acceptable** AVERAGE LEVEL of pain would be? _____

11. **Sleep** disturbance (difficulty falling/staying asleep) Yes / No. If yes **duration:** _____

12. Were you told that you snore while you are sleeping? No / Yes If yes did you have any sleep studies? Yes / No

13. Do you have perception of non-painful stimuli as being painful (Allodynia) Touch of cloths/bed sheets cause pain Yes / No

Character (quality) **of pain:** : **Nociceptive**: Dull ache, cramping, waxing, waning, sharp, tender._____

Neuropathic: Hot/burning, stabbing, electric shock, fan causing pain, tingling/numbness, shooting, pins/needles,

Which Movement is more painful? Is it Bending **Backwards**? Yes / No Is it Bending **forwards**? Yes / No

Altered feeling (Tingling / Numb / Burning / Bugs crawling / Electric shock like in Upper / Lower / extremities.

Do you have **muscle Spasms**? Yes / No How often? Frequently / Rarely / During night / None

Modifying Factors:

Pain aggravated by prolonged sitting, standing walking, bending squatting, climbing, lifting, pulling, pushing, and carrying

_____

Pain relieved by rest, lying down, hot shower, heating pad, medications, exercise, TENS, bio-feed back, physical therapy

_____

Functional Ability in relation to pain and comfort on a daily basis with out pain medications:

How is your ability to manage your relationship with others: _____

What is your ability to do daily activities or job: _____

Past treatments for the presenting problem (**When, where, who performed & their efficacy**):

Previous Treatments	Yes	No	Helpful	Not helpful
Physical Therapy Tried?				
TENS Unit Tried?				
Tried Weight loss?				
Pain Blocks Tried?				
Exercise program tried?				
Councelling/Biofeed/Prolo				

H/O NSAIDS (Naprosyn, Ibuprofin etc) usage & the reasons for their **failure** (side effects, Erosive Gastritis, GERD, Bleeding, cannot tolerate Vioxx, Celebrex, None of them are effective, They are effective one time but not any more

Are you taking any Anxiety & Depression Medications(circle): Xanax / Ativan / Klonipen / effexor / lexapro / abilify / seroqu

Medication History other than pain meds for the last 5 years:

Which **pain** medication(s) has helped: _____

Which **pain** medication(s) has not helped: _____

Are you on any **Blood thinners**? Aspirin / Plavix / Coumadin / NSAIDs / Tyclid / Alternative Health Remidies _____

Side effects of current or recent medication: None / Constipation / Nausea / Dry mouth / Sweating _____

Medication Allergies: Cannot tolerate NSAIDS / Tylenol with Codine / Morphine / Oxycodone / Ultram

If you are allergic what happened describe each one in detail: _____

Have you used? (Circle) Neurontin, Topomax, Lyrica, Elavil, Trazadone, lidoderm, dilantin, tegretol, Flector patches

Did they help ? Yes / No _____

Quality of family life, Activities of daily living & social life improved with medications **Yes / No**

Functional with medication: Working, Not working but functional, Functional with some limitation, Not functional **Yes / No**

Are you in compliance with treatment provided by your former doctors: **Yes / No**

III: **Review of Systems**: (Symptoms related to each system and how long)

Head aches, Duration Does it last longer than 4hrs Y / N Is the Head ache Moderate to Severe Y / N

Do you stay in dark room (Photophobia) Y / N Is your Head ache aggravated by physical activity Y / N

Do you suffer from Head-ache 15 days in a month, lasting more than four hours a day for longer than 3 months Y / N

Aura: Present / Not Present / Associated with Nausea / Need to stay in dark room / Morning / Evening

Anxiety & Depression & Duration (State how these effected by pain) _____

Have you been seen by a **psychiatrist / Psychologist** No / Yes by Dr _____

Do you have any suicide thoughts: Yes / **No**

Eyes: **Normal**/ Dry eyes/_____ ENT: **Normal**/Dry Mouth _____

Lungs: **Normal** Smokers Cough / COPD / Bronchitis / Asthma / Shortness of breath / Sogrens / Sarcoid

Heart: **Normal** Dizziness with standing / Heart attack / Angina / Rapid Heart beat / Irregular heart beat

Gastro Intestinal: **Normal** Intestinal, Large Bowel, Ulcer, Reflux Disease, Colitis, Irritable Bowel, Constipation

Kidney & bladder: **Normal**, Bladder incontinence, Stones _____

Endocrine: **Normal** / Diabetes / Hypothyroid: Use Medicines by mouth / Insulin / Sexual dysfunction _____

Patients Name: _____

Patient Name: _____ Date____/____/2012

Blood / clotting / Lymphatic / Anemia, sickle cell, **Normal**_____

Infectious Diseases: **Normal** / HIV / Hepatitis B / Hepatitis C / Herpes _____
Neurologic: **Normal**, Neuropathy / Seizures / Parkinsons / Restless leg / Dizzy / Falls / Fainting / MS
Psychiatric: **Normal**, Depression / Anxiety Neurosis / Panic disorder Bipolar / Personality Disorder
Musculoskeletel: **Normal**, Fibromyalgia / Spasms / Morning Stiffness / Arthritis / Lupus / Osteoporosis
Cancer: **None**, Liver / Ovary / Lung / intestine / Bladder / Brain / Breast / Prostate_____
Do you have: Low Blood Pressure / Too Much or Too little Sweating / red or white skin discoloration

IV: Past Medical/Surgical, Test done in the past 1 year for the present problem and their duration

Disease (Circle)	Year Diagnosed Medications used for treatment
Diabetes / Cancer / COPD / Hepatitis C Seizures / Thyroid / B12 / HIV / AF	
↑ Blood pressure / Heart Problems	
Syncope / falls / Chemo / Radiation	
Ulcer disease / Gastric Reflux /HiatalHernia	
Arthritis: Back Neck Knee Ankle Hip Shoulder	

List any surgeries? Did surgery help? Indicate by **YES or NO** (Circle)

Type of surgery & Hospital name & Doctors name	Helped	Approximate Date/Month/Year
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	

Which of the following tests you had in the past year? (If you have any reports please bring)

Name of the test	Approximate Date	Result of the Test as you understand
X-Rays		
CT / MRI scan		
EMG Report		
Consultations(Neurosurgery, Neurology)		
Brain Bone EKG scan		

PSYCHOLOGICAL EVALUATION **OARRS REPORT** **PHARMACY REPORT**

MEDICATION LIST **MEDICATION AGGREMENT** **URINE FOR TOX SCREEN** **DAST**

Family History: (paternal/maternal/siblings): Neuropathy / Diabetes / Back problems / Cancer / Drug related _____
Children (ages)(Supporting / Not supporting):_____
Sexual dysfunction Yes Secondary to / physical / psychological / medications / Diabetes _____No

If yes decrease / loss of desire / delay / unable to achieve orgasm / Loss of potency / unable to sustain erection / Trouble sweating

Social History: Single / Married / Divorced / Widowed / Living with _____

Current Work status: Working Full time / Part time / Retired / Disabled / Looking for **Last worked**: ___/___/____

Job responsibilities (Detailed) (Repetitive using wrist, shoulders, back, heavy lifting, typing, mental, pressure, crawling, bending etc.)

_____

Work place Ergo metrics (Circle): Drive Long distance to work / Repetitive tasks / Twisting & lifting / Long sitting / Key Board

Not working / Home maker / Sedentary / Function with some limitations / Not functioning / _____

Education- school / college _____

Smoking: Yes / No If yes Packs per day _____Do you wish to Quit smoking ? Yes / No Quit_____

Alcohol use: No / Yes; If yes social / moderate / Used for _____years Quit when _____

Past street drug dependency / abuse: No / Yes If Yes Use Drug Abuse Screening Test form_____

If yes since when/What/How long/Last time used _____

Family History of Substance abuse: No / Yes **History of Preadolescence sexual abuse:** No / Yes

C: Have you ever tried to cut down on your alcohol or drug use? Yes / No **A:** Do you get annoyed when commented about drinking or using drugs? **Yes / No** **G** Do you feel guilty about things you have done while drinking or using drugs? Yes / No

E: Do you need an eye-opener to get started in the morning? Yes / No

Have you had any fractures or dislocations of your bones or joints (excluding sports injuries)? Yes / No

Have you been injured in a traffic accident? **Yes / No** Have injured your head (Excluding sports injuries) Yes / No

Are you in fight or been assaulted while intoxicated **Yes / No** Have you been injured while intoxicated Yes / No

Compensation: No / Yes what type BWC –Self Insured / state / federal; social security: SSI / SSD_____

If any pain related to injury at work / personal injury: **No / Yes**

If yes; who was the employer / responsible party at the time of injury _____

Do you have more than one claim **No / Yes** Claim # _____

Do you use any **assist devise** (Circle if applicable): No / Cane / Walker / Crutch / Wheel chair / Scooter _____

Does your pain interfere with your ability to Carry Groceries / Climb stairs / bathe / dress / ability to use bath room / personal grooming

How would you rate your overall **energy?** (0-10) : _____ How would you rate your strength & endurance? (0/10 scale): _____

How would you rate your feeling of depression (0-10 scale): _____ How would you rate your feelings of **anxiety** (0-10) : _____

How would you rate your strength, endurance, energy and overall physical activity (0-10 scale) : _____

Where can we get your Medical records. Provide names & phone numbers (MRI, X-rays notes etc): _____

_____

_____

I listed all my medications in the **pain contract** form. The above information, I provided is accurate to the best of my knowledge.

Signature of the patient.:_____

Available data reviewed include:

1) Medical records from prior physicians reviewed include MRI Medications Progress notes Operative report X-rays Pharmacy bottles

2) UDS: Done Reviewed waiting for confirmation_____

3)OAARS Report: Reviewed Single group / Multiple Prescribers_____

4)_____

_____ _____ _____/_____/2012

Reviewed, Assisted & **Signed by Assistant** Reviewed, corrected & Signed by Physician

B. K. Reddy, S. Erragolla, L. Mathai Dr. L. Goodson

Dayton PainCenter
Accredited Pain Management

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Merrill Bolton, CRNA

Patient's Name: _____ Date: ____/____/2012

Please circle the following symptoms if you are experiencing Circle things apply to you?

Constipation.	Yes / No
Diarrhea.	Yes / No
Feeling full after only a few bites.	Yes / No
Nausea after eating.	Yes / No
Swollen abdomen.	Yes / No
Unintentional loss of more than 5% of body weight.	Yes / No
Vomiting of undigested food.	Yes / No
Blood pressure changes with the position.	Yes / No
Dizziness occurs when standing up.	Yes / No
Difficulty beginning to urinate.	Yes / No
Feeling of incomplete bladder emptying.	Yes / No
Urinary incontinence (lower flow incontinence).	Yes / No
Abnormal sweating (too much sweating or too little sweating).	Yes / No
Do you feel like Fainting, Dizzy, unsteady when walking , has fallen, has Balance problems, Vertigo	Yes / No
Heat intolerance.	Yes / No
Male impotency.	Yes / No
Rapid heart rate or abnormally slow Heart rate	Yes / No
Difficulty swallowing.	Yes / No
Do you have Lightheadedness or dizziness / Palpitations / Presyncope / Sense of weakness?	Yes / No
Do you suffer from Diabetes / Amyloidosis / Sarcoidosis / Irregular Heart beat / Fibromyalgia /	Yes / No
Are you taking insulin / Oral Diabetic Medications?	Yes / No
Do you have Blackouts and Seizures, unsteady when walking and climbing, Have Stroke affecting Balance?	Yes / No
Do you suffer from burning pain, tingling or numbness, Excessive sweating?	Yes / No
Does the fan blowing cause increase in your pain over your feet and hands?	Yes / No
Do you have the feeling of bugs crawling on your hands and feet?	Yes / No
Do you feel Dizzy, Feel like you may fall or have fallen in the past?	Yes / No
Does your feet turn purple when you stand and with swelling?	Yes / No
How much alcohol do you consume?	Yes / No
Do you suffer from Parkinson's disease, multiple sclerosis, HIV and AIDS, alcoholic neuropathy?	Yes / No
Diabetic neuropathy, Sjögren's syndrome, systemic lupus erythematosus, or post herpetic polyneuropathy?	Yes / No
Are you on Hypotensives, neuroleptics, hypnotics/anxiolytics, antiarrythmics, antiparkinsons medications?	Yes / No
Have you been diagnosed with any cancer? Did you receive any chemotherapy or radiation?	Yes / No
Do you have loss of Balance while walking, objects spinning or turning around you, have tendency to fall?	Yes / No
Were you diagnosed with Hypothyroidism / Premature Menopausal symptoms / Guillain-Barré syndrome?	Yes / No
Did you Undergo Gastric bypass Surgery?	Yes / No
Do You suffer from Sleep Apnea / Sleep disorders / Asthma / COPD?	Yes / No
Do you suffer from Depression / Anxiety / Panic Disorder / PTSD / Attention Deficit Disorder?	Yes / No
Were you diagnosed to have Peripheral Neuropathy?	Yes / No
Do You use Cane, walker, wheel chair or any assistive devise?	Yes / No

_____ _____

Patient's Signature Drs. B. K. Reddy / S. Erragolla / L. Matahi / P. Nuthakki / L. Goodson / PA Grace/ Crull/ Chasteen

Rx: **AFT QSART 2 4 6 8 Sites EMG NCS BLE / LLE / RLE / BUE / RUE / LUE Fall Risk Testing**

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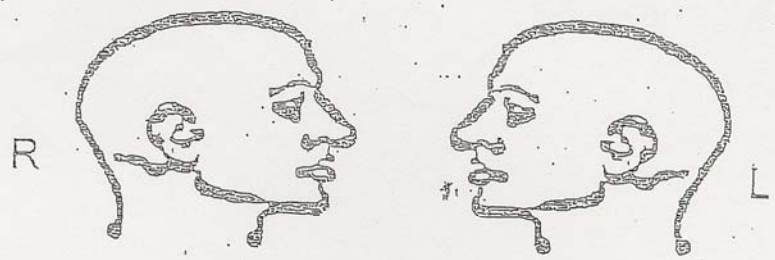
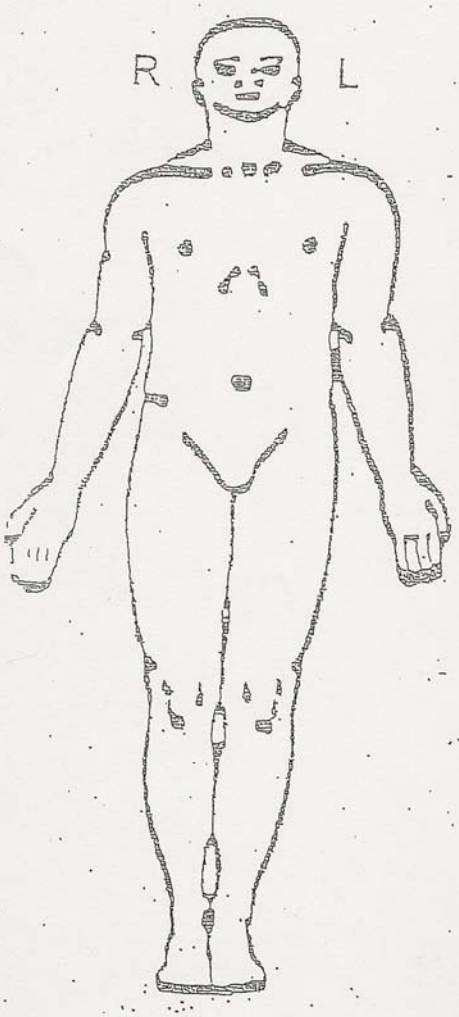
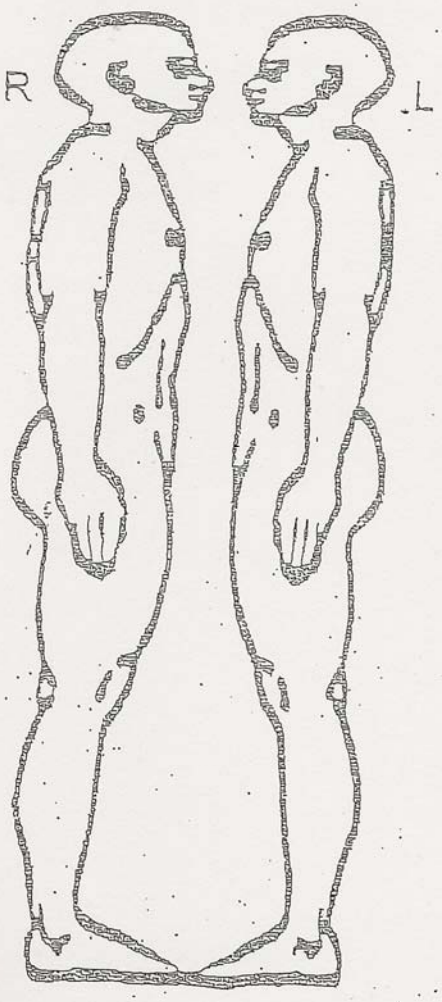
ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

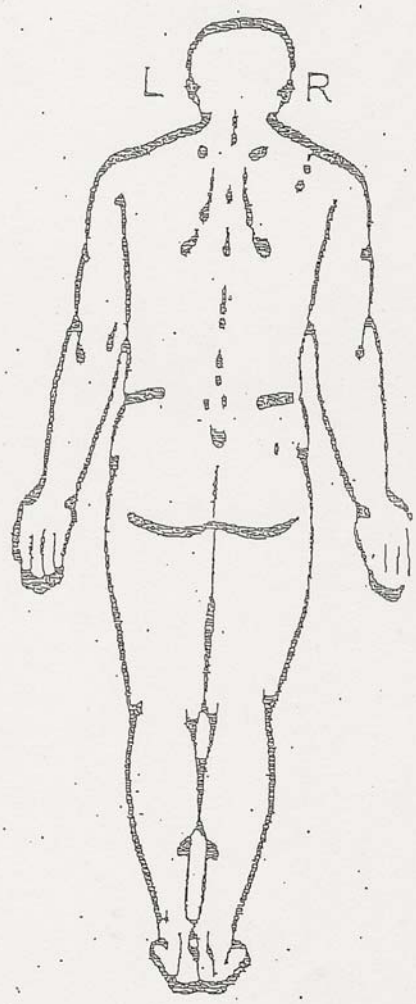
Patient Name _____ Date _____

Please shade in with a pencil the areas where you feel pain.









CURRENT MEDICATIONS AND PREVIOUSLY TAKEN PAIN MEDICATIONS

I am **currently taking** the following medications:

Name of the medication	Amount in Mg (How many mg/pill)	How often per day	Prescribing Physician

I have taken the following **Pain** medications in the **past**:

Name of the medication	Amount in Mg (How many mg/pill)	How often per day	Prescribing Physician

This is a true accounting of my medications.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____/_____/2011

DAYTON PAIN CENTER, LLC.
PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ SSN#: ____-____-____ DOB: ____/____/20____

Sex: M / F Address: _____ City: _____ OH Zip: _____

Home Tel #: _____ Work Tel #: _____ Cell Tel # _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Marital Status: Single / Married / Widowed Family Doctor: _____ Tel # _____ Fax_____

Spouse's Name: _____ Spouse's SSN#: _____/_____/_____

Spouse's Employer: _____ Spouse's Employer Tel #: _____

Spouse's Emp. Address: _____ City: _____ OH Zip: _____

Who may we thank for referring you to us: _____ Tel #: _____

Referring Physician Name: _____ Tel #: _____ Fax # _____

Ref Physician Address: _____ City: _____ OH Zip: _____

Reason for Referral: _____

In case of emergency who may we contact: _____ Tel # _____

Is this visit due to injury: Yes / No Type of injury: Auto / BWC

Nearest relative not living with you: _____ Tel # _____

Nearest friend not living with you: _____ Tel # _____

Landlord Name: _____ Tel # _____

INSURANCE INFORMATION Financial Responsible party for this bill _____

Insurance Name: _____ Policy # _____ Group # _____ ID # _____
Address: _____ City: _____ State: _____ Zip: _____
Tel # _____ Insured Name: _____ SS# _____
Secondary Insurance: _____ Policy # _____ Group # _____ ID # _____
Address: _____ City: _____ State_____ Zip _____
Tel # _____ Insured Name : _____ SS # _____
Workers Compensation: Company: _____ Address: _____
Telephone # _____ Claim # _____ Date Of Injury: ____/____/_____ Case worker_____

AUTHORIZATION: I hereby authorize DAYTON PAIN CENTER, LLC. to release any information concerning my illness and treatments and that of my dependents. I also authorize payment of medical benefits of DPC for services rendered. I understand and agree (regardless of my status) that I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completes all the answers. I CERTIFY this information is true and correct to the best of my knowledge. I will notify any changes in my status or the above information.

Responsible party Signature: _____ Date: _____/_____/20__