ADVANCED INTERVENTIONAL PAIN MANAGEMENT, PA

Name_____ Date_____ MRN_____

Date of Birth_____ Race_____ Ethnicity_____ Language_____

Address_____ County_____

Daytime Phone_____ E-Mail Address_____

Emergency Contact_____ Phone_____

Primary Physician_____ Referring Physician_____

Reason for Today's Visit_____

Approximately how long have you been having pain?_____

How did your pain begin?_____

How often do you experience pain?_____

What makes your pain worse?_____

What makes your pain better?_____

How does pain interfere with your life?_____

Does it affect your sleep? Yes No

Circle all the words that describe your pain:

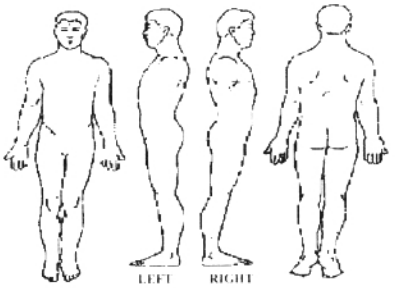
Throbbing	Dull	Shooting	Cutting	Cramping	Burning	Aching
Stinging	Stabbing	Electric	Sickening	Tender	Sharp	Prickling
Constant	Frequent	Rare	Occasional	At Night	Daily	Unbearable

Circle the number on the scale below that describes your AVERAGE level of pain:

No Pain Worst Pain Ever

1 2 3 4 5 6 7 8 9 10

Where is the pain located? Please color or shade the areas on the body where you experience pain.



VITALS: BP_____ PULSE_____ TEMP_____ RESP_____

List ALL prescriptions and over-the-counter medications you have taken in the last 30 days:

_____ _____ _____

_____ _____ _____

_____ _____ _____

List ALL medications you have had an allergic or undesired reaction to:

_____ _____ _____

_____ _____ _____

_____ _____ _____

What surgeries, x-rays, or emergency room visits have you had since your last visit, and where were you treated?

_____

_____

_____

Have you had any changes in Family, Social, or Medical history since you last visit?

_____

_____

_____

Circle any of the following that you experience:

Fever	Weight Loss	Changes in Vision	Blurry Vision	Shortness of Breath
Hoarseness	Chest Pain	Double Vision	Nosebleeds	Chest Tightening
Palpitations	Cancer	Ringing in Ears	Swelling	Heat/Cold Intolerance
Depression	Seizures	Bloody Mucus	Fainting	Loss of Bladder Control
Fatigue	Dizziness	Easy Bleeding	Constipation	Loss of Bowel Control
Heartburn	Diarrhea	Painful Urination	Hallucinations	Skin Rash/Redness
Vomiting	Headaches	Blood in Urine	Blood in Stool	Muscle Cramps

History taken by: **Reviewed by:** **Date:**