

# 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

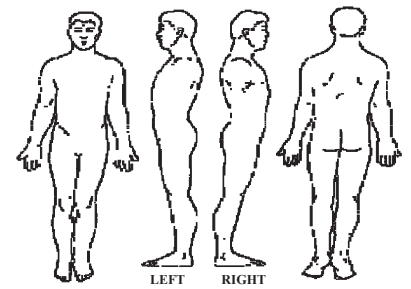
Circle the number on the scale below that describes your AVERAGE level of pain:

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.



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

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

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

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

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**Circle any of the following that you experience:**

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|--------------|-------------|-------------------|----------------|-------------------------|
| Fever        | Weight Loss | Changes in Vision | Blurry Vision  | Shortness of Breath     |
| Hoarseness   | Chest Pain  | Double Vision     | Nosebleeds     | Chest Tightening        |
| Palpitations | Cancer      | Ringling 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           |