

Patient Name: _____

DOB: _____

DOS: _____

Integrative Pain Center

of Arizona

PATIENT HISTORY

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Accurately completing the intake below will help us to better understand and assess your pain, and to begin the best possible treatment program for you. Please be assured that our records are strictly confidential and no one outside of your health care team is permitted to review your case record without your written consent.

SECTION 1 – BACKGROUND INFORMATION

Patient:

First Name _____ Last Name _____ Middle Initial _____

Address _____ City _____ State _____

Zip Code _____ Phone No _____ Fax No _____

Email _____ Date of Birth _____ Age _____

Driver's License No _____ State Issued _____ SSN _____

Height _____ Weight _____

Reason for Today's Visit _____

SECTION 2 – EMPLOYMENT HISTORY

Do you work? ___ Yes ___ No **If No, last occupation or work experience** _____

If Yes, please complete the following

Employer _____ Title _____

Address _____ City _____ State _____

Zip Code _____ Phone No _____ Fax No _____

Length of Employment _____ Full-time ___ Part-time ___ Self-Employment ___

ACKNOWLEDGEMENT

Patient Name/Signature

Date

Patient Initials _____1

Patient Name: _____

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DOS: _____

SECTION 3 – PROVIDER INFORMATION

NOTE: Physicians at Integrative Pain Clinic of Arizona do not conduct Disability Assessments. To prevent delays, all disability requests should be routed through your Primary Care Physician

Primary Care Physician (PCP)

Name _____

Address _____

Phone _____

Fax _____

Referring Physician (RP) (Complete only if different from Primary Care Physician)

Name _____

Address _____

Phone _____

Fax _____

Please list other physician specialists you have seen:

Name _____ Reason _____

Name _____ Reason _____

Name _____ Reason _____

SECTION 4 - PAIN ASSESSMENT

Did an injury cause your pain? _____ Yes _____ No

If Yes, how long the pain has the pain bothered you (give the date/year) and describe the injury:

If you are employed, does your pain interfere with your work? If yes, please explain:

Please check as many of the activities below that appropriately describe your typical daily activities:

_____ Computer Work _____ Lifting _____ Sitting _____ Standing _____ Reclining

_____ Driving _____ TV _____ Reading _____ Other (explain)

Patient Initials _____ 2

Patient Name: _____

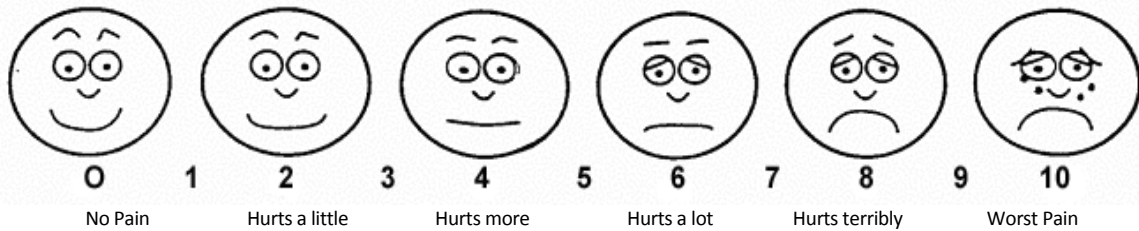
DOB: _____

DOS: _____

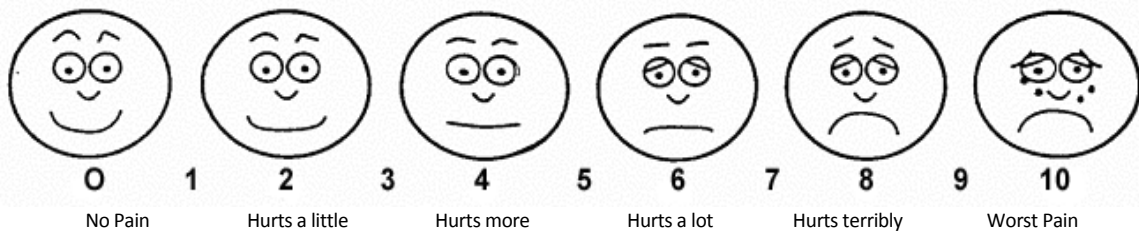
Pain is a *subjective* experience. Please use this scale to help us understand the severity of your suffering. (Check one)

- 1-4 Pain that doesn't prevent you from participating and completing daily activities.
- 5 Pain that makes you feel you need medication, but doesn't force you to stop your activity. You can delay taking medicine so the current task(s) can be completed without interruption.
- 6-7 Pain that is severe enough to stop any tasks and necessitates immediate medication.
- 8-9 Pain so severe and debilitating that someone else has to get your medication(s) for you.
- 10 Absolutely the worst pain. You are completely disabled.

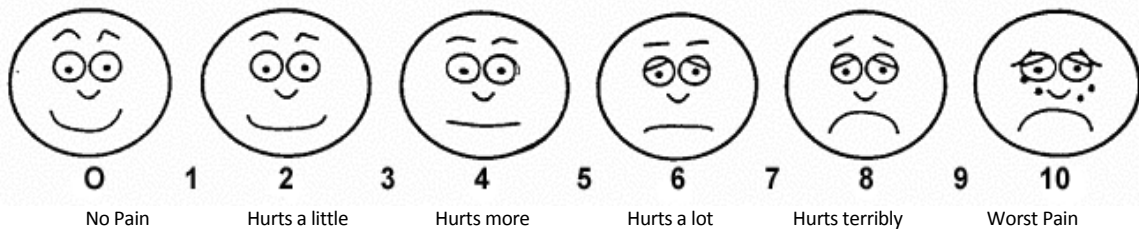
7. Which face shows how much you hurt **now**? Put an "X" on the face.



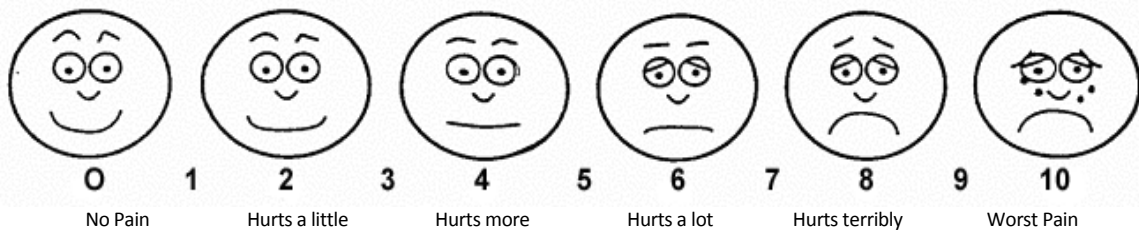
8. Which face shows how much you hurt with your **worst** pain? Put an "X" on the face.



9. Which face shows how much you hurt when your pain is at its **least**? Put an "X" on the face.



10. Which face shows how much you hurt on **average**? Put an "X" on the face.



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11. Indicate whether the following activities make your pain **better** or **worse**?

Activity	Better	Worse	No Change	Activity	Better	Worse	No Change
Alcohol				Pain Pills			
Bending				Pushing			
Bowel Movement				Sex			
Cold/Ice				Sitting			
Dampness				Standing			
Activity	Better	Worse	No Change	Activity	Better	Worse	No Change
Heat				Staying Busy			
Lifting				Stress			
Lying Down				Urination			
Moving Around				Walking			

12. To avoid worsening of your pain, please describe your limits:

How far can you walk? _____

How long can you stand? _____

How much can you lift? _____

How long can you sit? _____

Because of your pain, what percentage of time is lost from:

Work _____

Housework _____

Social Activities _____

Sleep _____

Recreational Activities _____

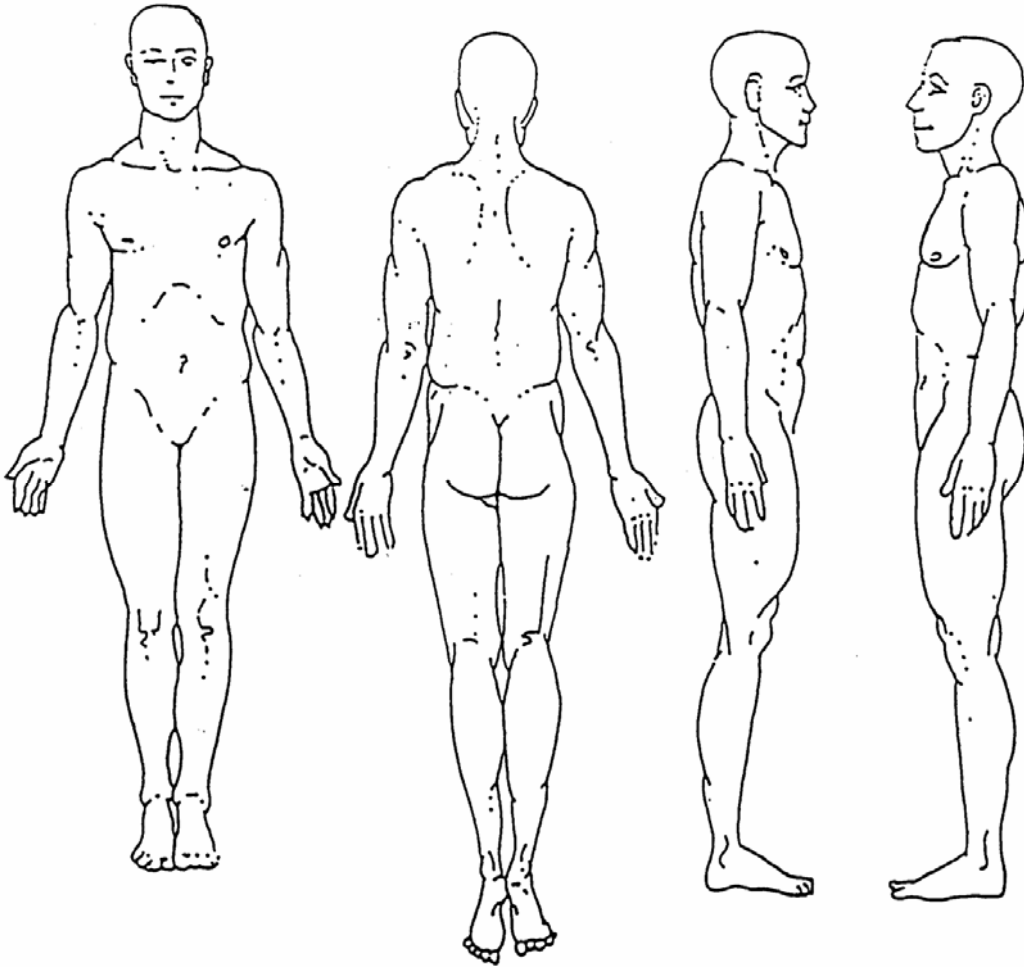
Sexual Relations _____

Patient Name: _____

DOB: _____

DOS: _____

Please fill in the "Pain Diagram" below to let us know where your pain is and where it hurts the worst. Shade or color the areas on your body where you feel pain. Mark **Severe Locations with "O"s** and use an **"X" where it is the Worst**.



13. Check *all* words that describe your pain (Check more than one, if necessary):

<input type="checkbox"/> Aching	<input type="checkbox"/> Sharp	<input type="checkbox"/> Penetrating
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Tender	<input type="checkbox"/> Nagging
<input type="checkbox"/> Shooting	<input type="checkbox"/> Burning	<input type="checkbox"/> Numb
<input type="checkbox"/> Stabbing	<input type="checkbox"/> Exhausting	<input type="checkbox"/> Miserable
<input type="checkbox"/> Gnawing	<input type="checkbox"/> Tiring	<input type="checkbox"/> Unbearable
Other (please list): _____		
Have you seen other doctors for your pain? <input type="checkbox"/> Yes <input type="checkbox"/> No		

If yes,

Physician Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Patient Name: _____

DOB: _____

DOS: _____

14. Have you had surgery for your pain? _____ Yes _____ No

If yes, please list surgeries:

Date	Hospital or Clinic	City	Surgery

15. Have you had any of these tests?

DATE	TEST	PLACE	RESULTS
	X-Rays		
	CAT Scan		
	MRI Scan		
	Bone Scan		
	Myelogram		
	EMG Nerve Test		
	Other <i>(Please List)</i>		

16. What other medical problems do you have?

17. Do have any allergies? _____ Yes _____ No

If yes, to what, and what was your reaction?

ALLERGY	REACTION

18. Are you allergic to any of the following:

Iodine _____ Yes _____ No

Tape _____ Yes _____ No

X-ray dye _____ Yes _____ No

Patient Name: _____

DOB: _____

DOS: _____

DOS _____

DOS _____

Please fill in the boxes below with your current medications including the dosage and direction for taking the medication. List pain medications first.

Patient Name: _____ DOB: _____

PCP: _____ Referring Dr: _____

Drug Name, Dosage & Sig	Date	Patient Initials	Drug Name, Dosage & Sig	Date	Patient Initials

Patient Name: _____

DOB: _____

DOS: _____

19. PAIN MEDICATION SIDE EFFECTS

The following effects can occur in people taking pain medication. If you are having any of these from your medication, place an X next to the level of intensity: **MILD, MODERATE OR SEVERE.**

- | | <u>MILD</u> | <u>MODERATE</u> | <u>SEVERE</u> |
|---|-------------|-----------------|---------------|
| Nausea | | | |
| Itching | | | |
| Rash | | | |
| Flushing | | | |
| Sweating | | | |
| Feeling Drunk | | | |
| Dizziness | | | |
| Poor Concentration | | | |
| Shakiness | | | |
| Increase Tiredness | | | |
| Poor Sex Drive | | | |
| New Or Increase Leg Or Foot Swelling | | | |
| Difficulty Urinating | | | |
| Constipation | | | |
| Increase Joint Pain Since Starting The Medication | | | |
| Sweats | | | |
| New Headache | | | |
| For People Using The Duragesic Patch: | | | |
| Skin Irritation At The Site Of Medication Patch | | | |
| Medication Patches Don't Stick Well | | | |

20. Social History:

Marital Status: _____ Single _____ Divorced _____ Married

Who lives with you? _____

Do you smoke _____ Yes _____ No

How many packs per day? _____ For how long? _____

Do you drink alcohol? _____ Yes _____ No

of drinks when you drink? _____ Do you drink alcohol daily? _____ Yes _____ No

What types of alcohol do you drink? _____

21. Family History:

Do any medical problems run through your family? _____ Yes _____ No

If yes, what?

Are your parents living? _____ Yes _____ No

If not, at what age did they die and what caused their death? _____ Mother _____ Father

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23. Have you had any problems with misuse of prescription medications, alcohol, street drugs or other substances? _____ Yes _____ No

24. What is your goal for pain control?

Please feel free to use the remaining space to add any additional information that you believe will be pertinent to your evaluation.

Thank you for taking the time to fill out this questionnaire. Your participation will help us determine the best course of treatment for you.

I have reviewed all pages of this Patient History Packet with the patient today.

Bennet Davis, M.D. Mitchell Halter PhD, M..D., Kathy Davis, ANP Beverly Webber, FNP

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