PAIN RELIEF
OF DAYTON

Interventional Pain Medicine
for Spine & Chronic Pain Care
Board Certified • Fellowship Trained

www.painreliefofdayton.com

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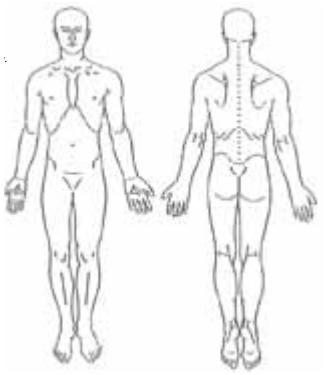
PATIENT NAME: _____ DATE OF BIRTH: _____

On the figure below, please circle the areas of pain. Elaborate if necessary.



_____

_____

_____

_____

How does your pain affect your sleep? Check what applies:

❑Trouble falling asleep ❑Medication needed to fall asleep ❑ Awakened by the pain

Does the pain affect your desire and/or ability for sexual relations? Y/N

Are you: ❑Employed ❑Retired ❑Disabled ❑ Unemployed ❑Looking for work

What is your occupation? _____ **Full Time** _____ **Part Time** _____

Do you receive disability benefits? Y/N **Are the benefits**: Partial Total Temporary Permanent

Are you involved in any legal proceedings related to your pain condition? Y/N

Have you ever received psychiatric or psychological counseling for your *pain* condition? Y/N

Have you been treated by other physicians for your pain condition? Y/N **If so, please list:**

Functional Review

Because of a physical, mental or emotional condition, do you have difficulty with any of the following activities?

Concentrating/Making Decisions/Remembering Y/N
Walking or climbing stairs Y/N
Dressing or bathing Y/N
Performing errands alone such as shopping or visiting a physician Y/N
Are you Blind Y/N Are you Deaf Y/N

If your pain condition affects your daily life in other ways, please describe:

_____
_____

Please check the following things that improve your pain: ❑Liquor ❑Heat ❑Massage/Pressure ❑No Movement ❑Movement ❑ Rest/Sleep ❑Cold ❑Lying Down ❑Distraction ❑Working ❑Mild Exercise

Tell us about your current pain condition. Please answer the following:

Chronicity: ☐New ☐ Recurrent ☐Chronic

Onset: ☐Today ☐Yesterday ☐In the past 7 days ☐1-4 Weeks ago ☐ 1+ Months ago
☐ More than 1 year ago

Frequency: ☐Constantly ☐2-4 times per day ☐Daily ☐Every several days ☐ Intermittently ☐Rarely

Progression Since Onset: ☐Unchanged ☐Gradually Improving ☐ Rapidly Improving ☐Comes and Goes
☐Resolved ☐ Gradually Worsening ☐Rapidly Worsening

Pain Location:

_____

_____

Pain Quality: ☐Aching ☐Burning ☐ Cramping ☐ Shooting ☐Stabbing ☐Tingling

Pain Radiates to: ☐Does not radiate ☐Legs/Feet ☐Arms/Hands ☐Hip/Thigh

Pain Score (Please Circle): least pain 0 1 2 3 4 5 6 7 8 9 10 most pain

Pain Severity: No Pain Mild Moderate Severe

Aggravated by: ☐Bending ☐Lying ☐Sitting ☐Stress ☐Coughing
☐Position ☐Standing ☐Twisting

Pain is: ☐Worse during the day ☐Worse during the night ☐Same all the time

Stiffness is present: ☐In the morning ☐At night ☐All the time

Associated Symptoms: ☐Abdominal pain ☐Bladder Incontinence ☐Bowel Incontinence ☐Chest pain
☐Fever ☐Headaches ☐Leg pain ☐Numbness ☐Pelvic pain ☐Tingling
☐ Weight loss ☐Weakness

Risk Factors: ☐Cancer ☐Osteoporosis ☐Steroid use ☐Lack of exercise ☐Menopause ☐Obesity
☐Poor posture ☐Pregnancy ☐Recent trauma ☐Sedentary lifestyle

Treatments Tried: ☐Nothing ☐ Medications ☐Bed rest ☐Chiropractic ☐Heat ☐Home exercise
☐Ice ☐Walking ☐Injections ☐Surgery ☐Physical therapy

Improvement on Treatment: ☐No relief ☐Mild ☐ Moderate ☐Significant

Family History Please check all that apply.

Relation	High BP	High Cholesterol	Cancer	Diabetes	Pain Conditions	Spine Conditions	Heart Trouble
Mother							
Father							
Sister							
Daughter							
Brother							
Son							
MGM							
MGF							
PGF							
MGF							
Other							

Social History Please check all that apply.

Alcohol Drinks Y/N _____ per week.

Tobacco Use Y/N _____ packs per day. Smoked for _____ years.

Daily Exercise Y/N

Have you had any of the following surgeries?

	Appendectomy		Tonsillectomy		Joint Replacement
	Brain Surgery		Breast Surgery		CABG
	Gall Bladder		Colon		C-Section
	Eye Surgery		Hernia Repair		Hysterectomy
	Spine Surgery		Valve Replacement		

Do you have any of the following Conditions?

	Allergies		Depression		Nerve Trouble		Glaucoma
	Anemia		Diabetes		Osteoporosis		Hepatitis C
	Anxiety		Emphysema		Seizures		
	Arthritis		GERD		Stroke		
	Asthma		Heart Murmur		Substance Abuse		
	Cancer		HIV/AIDS		Hypertension		
	Cataracts		Hyperthyroidism		Goiter		
	Thyroid disease		Hypothyroidism		Tuberculosis		
	CHF		Kidney Disease		Ulcers		
	Clotting Disorder		Heart Problems		High cholesterol		
	COPD		MI		Gout		

Review of Systems Do you have any of the following symptoms?

Constitution		**Eyes**		**GU**		**Neurological**	
	Activity Change		Eye discharge		Difficulty urinating		Dizziness
	Appetite Change		Eye itching		Dysuria		Facial asymmetry
	Chills		Eye pain		Flank pain		Headaches
	Sweating		Eye redness		Frequency		Light-headedness
	Fatigue		Photophobia		Genital sore		Numbness
	Fever		Visual disturbance		Menstral problems		Seizures
	Weight gain/loss				Pelvic pain		Speech difficulty
		Respiratory			Urgency		Syncope
HENT			Apnea		Decreased urine		Tremors
	Facial swelling		Chest tightness		Vaginal bleeding		weakness
	Neck pain		Shortness of breath		Vaginal discharge		
	Neck stiffness		Chocking		Vaginal pain		
	Ear discharge		Cough			**Hematologic**	
	Hearing loss		Stridor	**MusculoSkeletal**			
	Ear pain		Wheezing		Arthraligias		Clotting disorders
	Tinnitus				Back pain		Anemia
	Nosebleeds				Gait problems		bruising
	Congestion	**Cardiovascular**			Joint pain		
	Runny nose		Chest pain		Joint swelling	**Psychiatric**	
	Postnasal drip		Leg swelling		Trouble walking		Agitation
	Sneezing		Palpitations				Behavior problem
	Sinus pressure						Confusion
	Dental problems	**GI**		**Skin**			Hyperactive
	Drooling		Abdominal distension		Color change		Anxiety
	Mouth sores		Abdominal pain		Pallor		Depression
	Trouble swallowing		Anal bleeding		Rash		Bi-polar
	Voice change		Blood in stool		Itching		Suicidal thoughts
			Constipation		Wound		OCD
			Diarrhea				
			Nausea				
			Rectal pain				
			vomiting				

Is there anything else you would like the doctor to know?

_____

_____

_____

Please list any current medications you are taking. Use a separate paper if necessary.

_____

_____

_____