

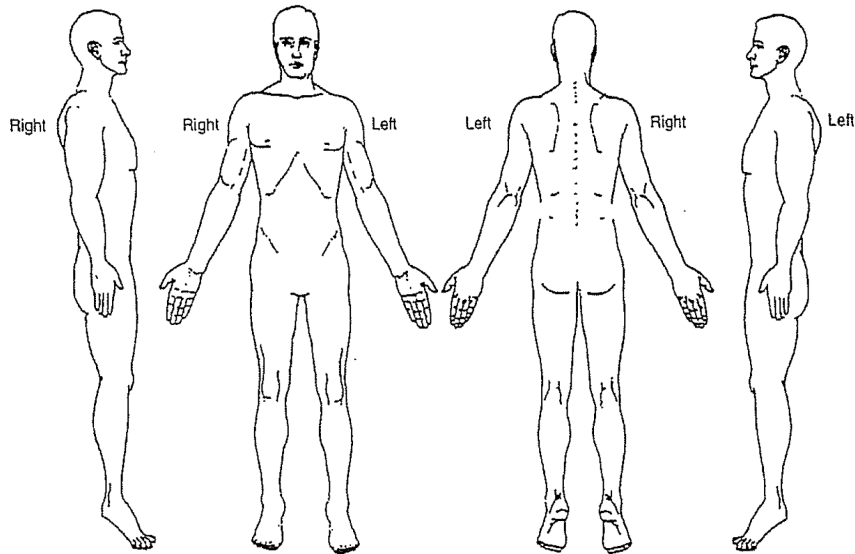
GENERAL

Patient Name	<i>Last Name</i>	<i>First Name</i>	<i>M.I.</i>	Today's Date (MM/DD/YY)
Gender	Male	Female	Height	Weight

Which doctor referred you to OSS Pain Management & Regenerative Medicine?

PAIN: What is the current level of your pain?

Mark the drawing below **with an X** to show where you have the most severe pain.
Shade in the areas where you have less severe pain.



On a scale of 0 - 10 (0=no pain, 10=worst pain possible), what is your level of pain? 0 1 2 3 4 5 6 7 8 9 10

How often do you have pain?

Constantly Comes & Goes Certain Time of Day: _____ With this Activity: _____

Have you been seen at a Pain Management Clinic before? No Yes

If yes, what was the the date(s), duration, and location / name of clinic? _____

How did your pain start?

Work Injury Illness No Obvious Cause Injury, Not at Work Motor Vehicle or Motorcycle Accident Other: _____

How long have you had this pain? _____

How would you describe how your pain feels? _____

What makes your pain feel:

Better? _____

Worse? _____

How is your sleep? Describe. _____

GENERAL

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HISTORY OF TREATMENT: How have you tried to manage the pain?

Have you used any of these treatment(s) to ease your pain? Please check as it applies, provide the date(s), and describe outcome.

				Date(s) Tried	Outcome / Reason(s) Stopped?
Services					
Physical Therapy	No	Yes		_____	_____
TENS Unit	No	Yes		_____	_____
Aqua Therapy	No	Yes		_____	_____
Acupuncture	No	Yes		_____	_____
Biofeedback	No	Yes		_____	_____
Spinal Cord Stimulation (SCS)	No	Yes		_____	_____
Relaxation, imagery, mindfulness	No	Yes		_____	_____
Injections					
Epidural Injection	No	Yes		_____	_____
Transforaminal (Nerve Block) Injection	No	Yes		_____	_____
Sacroiliac (SI) Joint Injection	No	Yes		_____	_____
Facet Injection	No	Yes		_____	_____
Trigger Point Injection	No	Yes		_____	_____
Rhizotomy Injection	No	Yes		_____	_____
Other	No	Yes		_____	_____
Regenerative Medicine					
Platelet Rich Plasma (PRP)	No	Yes		_____	_____
Stem Cell	No	Yes		_____	_____
Prolotherapy	No	Yes		_____	_____
Cartilage Regeneration	No	Yes		_____	_____
Nonsteroidal Medications					
Motrin (Ibuprofen)	No	Yes		_____	_____
Aleve	No	Yes		_____	_____
Naproxen	No	Yes		_____	_____
Mobic (Meloxicam)	No	Yes		_____	_____
Lodine (Etodolac)	No	Yes		_____	_____
Other					
Aspirin	No	Yes		_____	_____
Tylenol	No	Yes		_____	_____
Other	No	Yes		_____	_____
Muscle Relaxants					
Baclofen	No	Yes		_____	_____
Robaxin	No	Yes		_____	_____
Zanaflex	No	Yes		_____	_____
Skelaxin	No	Yes		_____	_____
Flexeril	No	Yes		_____	_____

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HISTORY OF TREATMENT: How have you tried to manage the pain?

Have you used any of these treatment(s) to ease your pain? Please check as it applies, provide the date(s), and describe outcome.

	No	Yes	Date(s) Tried	Outcome / Reason(s) Stopped?
Narcotics (Opioids)				
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Percocet	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Oxycodone	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hydrocodone (Norco)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Opana (Oxymorphone)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Morphine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Oxycontin	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Avinza	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hysingla	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Duragesic (Fentanyl)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Suboxone	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Neuromodulators				
Neurontin (Gabapentin)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Topamax	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lyrice	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cymbalta	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Gabitril	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

What allergies do you have? _____

SOCIAL HISTORY: What social factors should we consider in your care?

Have you ever used any of the following drugs? Check as it applies.

Marijuana Heroin Suboxone Sedative / Downers Inhalants Amphetamines Cocaine Bath Salts

Please check your response. Scale: 1 = Never, 2 = Seldom, 3 = Sometimes, 4 = Often, 5 = Very Often

How often do you have mood swings?	1	2	3	4	5
How often do you smoke a cigarette within an hour of waking up?	1	2	3	4	5
How often have you taken medication other than the way it was prescribed?	1	2	3	4	5
How often have you used illegal drugs in the past five years?	1	2	3	4	5
How often in your lifetime have you had legal problems or been arrested?	1	2	3	4	5

Comments: _____

Have you ever thought you should cut down on your drinking or drug use? No Yes

Have people ever annoyed you by criticising your drinking or drug use? No Yes

Have you ever had a drink or used drug in the morning to steady your nerves or get rid of a hangover? No Yes

Are you currently seeing a mental health provider or counselor? No Yes

AUTHORIZATION

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name (Print): _____

Patient Signature: _____ Date: _____