

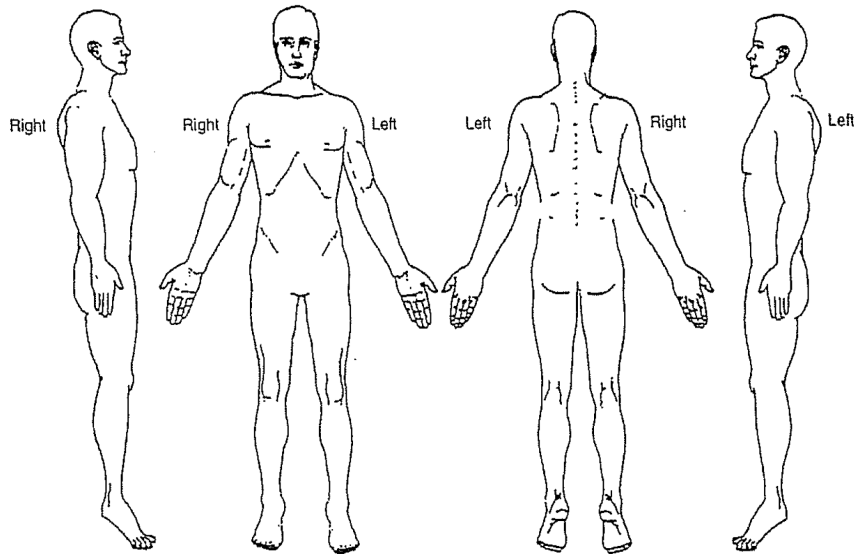
**GENERAL**

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**

Patient Name	<i>Last Name</i>	<i>First Name</i>	<i>M.I.</i>	Today's Date (MM/DD/YY)
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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?
<b>Services</b>					
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		_____	_____
<b>Injections</b>					
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		_____	_____
<b>Regenerative Medicine</b>					
Platelet Rich Plasma (PRP)	No	Yes		_____	_____
Stem Cell	No	Yes		_____	_____
Prolotherapy	No	Yes		_____	_____
Cartilage Regeneration	No	Yes		_____	_____
<b>Nonsteroidal Medications</b>					
Motrin (Ibuprofen)	No	Yes		_____	_____
Aleve	No	Yes		_____	_____
Naproxen	No	Yes		_____	_____
Mobic (Meloxicam)	No	Yes		_____	_____
Lodine (Etodolac)	No	Yes		_____	_____
<b>Other</b>					
Aspirin	No	Yes		_____	_____
Tylenol	No	Yes		_____	_____
Other	No	Yes		_____	_____
<b>Muscle Relaxants</b>					
Baclofen	No	Yes		_____	_____
Robaxin	No	Yes		_____	_____
Zanaflex	No	Yes		_____	_____
Skelaxin	No	Yes		_____	_____
Flexeril	No	Yes		_____	_____

**GENERAL**

Patient Name *Last Name* *First Name* *M.I.* Today's Date (MM/DD/YY)

**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?
<b>Narcotics (Opioids)</b>				
Codeine	No	Yes	_____	_____
Percocet	No	Yes	_____	_____
Oxycodone	No	Yes	_____	_____
Hydrocodone (Norco)	No	Yes	_____	_____
Opana (Oxymorphone)	No	Yes	_____	_____
Morphine	No	Yes	_____	_____
Oxycontin	No	Yes	_____	_____
Avinza	No	Yes	_____	_____
Hysingla	No	Yes	_____	_____
Duragesic (Fentanyl)	No	Yes	_____	_____
Suboxone	No	Yes	_____	_____
<b>Neuromodulators</b>				
Neurontin (Gabapentin)	No	Yes	_____	_____
Topamax	No	Yes	_____	_____
Lyrice	No	Yes	_____	_____
Cymbalta	No	Yes	_____	_____
Gabitril	No	Yes	_____	_____

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: \_\_\_\_\_