NEW PATIENT - ELLIOT PAIN MANAGEMENT and INTERVENTIONAL SPINE CENTER

1. How do the following affect your pain? (Please check one for each item.)

	Decrease	No Effect	Increase
Lying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Exercise (if applicable)	☐	☐	☐
Medication:			
Tylenol / acetaminophen	☐	☐	☐
Ibuprofen / NSAIDs	☐	☐	☐
Muscle relaxant	☐	☐	☐
Neuropathic pain reliever	☐	☐	☐
Opiates	☐	☐	☐

2. Are there other factors that make your pain

☐ Better? (Please list) _____

☐ Worse? (Please list) _____

3. Please rate your pain intensity on a scale from 0 = no pain to 10 = excruciating, incapacitating, worst pain possible. Rate your pain during the past month or since your injury. Write the number (from 0-10) below.

YOUR PAIN AT ITS WORST: _____ AT ITS LEAST: _____ ITS AVERAGE: _____

4. PLEASE CHECK ALL OF THE TREATMENTS YOU HAVE TRIED FOR PAIN RELIEF AND COMPLETE THE APPROPRIATE COLUMNS TO THE RIGHT:

		Where?	When? (Indicate if currently participating)	Helpful or not? YES	NO
	☐ **PHYSICAL THERAPY**				
	☐ Chiropractic				
	☐ Physiatry				
	☐ Exercise: PHYSICIAN DIRECTED				
	☐ Exercise: INDEPENDENT HOME EXERCISE				
	☐ Acupuncture				
	☐ Massage				
	☐ TENs (electrical stimulator)				
	☐ Ice/heat				
	☐ Traction				
	☐ Nerve block / other injection				
	☐ Surgery				
	☐ Other				

5. Have you ever been in treatment for misuse of alcohol, illicit drugs or prescribed medications?
If yes; where and when? _____

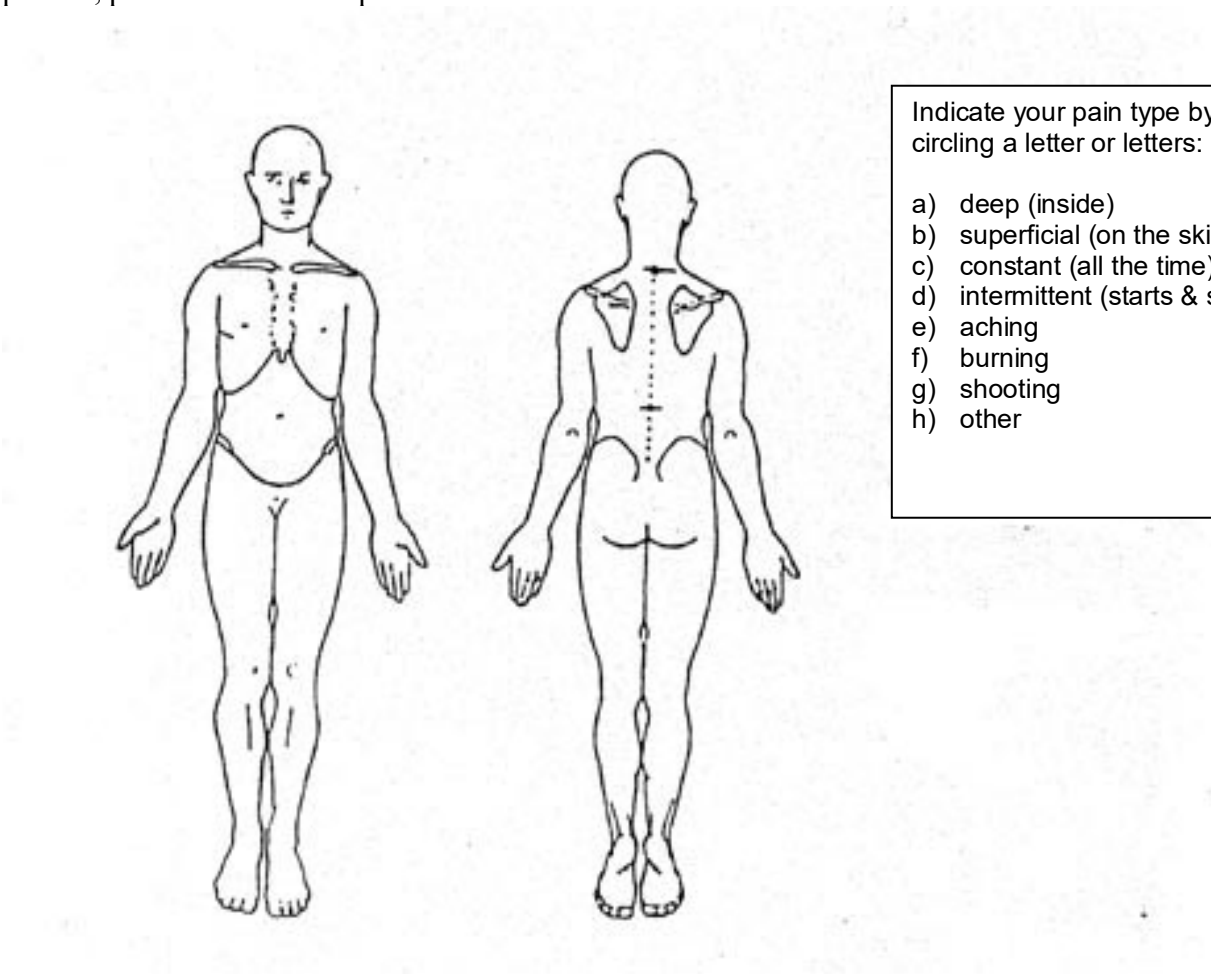
6. Have you ever had psychiatric, psychological, or social work evaluation or treatment?
☐ Yes ☐ No If yes, before the age of 18? ☐ Yes ☐ No After the age of 18? ☐ Yes ☐ No

7. Have you ever experienced any physical, emotional, or sexual abuse?
☐ Yes ☐ No If yes, before the age of 18? ☐ Yes ☐ No After the age of 18? ☐ Yes ☐ No

Patient Name (Please Print Clearly):

Date of Birth:

Please mark the location(s) of your pain with an "x" on the diagram below. If whole areas are painful, please shade in the painful area.



Indicate your pain type by circling a letter or letters:

a) deep (inside)
b) superficial (on the skin)
c) constant (all the time)
d) intermittent (starts & stops)
e) aching
f) burning
g) shooting
h) other

Does pain limit your ability to:

	YES	NO
Work?	___	___
Perform ADLs (activities of daily living)?	___	___
Participate in recreational activity?	___	___
Perform home duties?	___	___

OTHER: _____

_____

_____

Patient Name (Please Print Clearly):

Date of Birth: