



# Advanced Pain Centers, S.C.

## Pre Visit Questionnaire

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date of Service: \_\_\_\_\_ Provider To Be Seen: \_\_\_\_\_

Location of Pain: \_\_\_\_\_

HISTORY OF PRESENT ILLNESS Pain Scale: 1 2 3 4 5 6 7 8 9 10

1. CURRENT VAS \_\_\_\_\_ MAXIMUM VAS \_\_\_\_\_ MINIMUM VAS \_\_\_\_\_ AVG VAS \_\_\_\_\_

2. Date and description of the onset of pain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Describe your pain and the specific location(s) (radiating, burning, stabbing, aching etc).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. What activities increase your pain? (standing, sitting, walking, bending, lifting, etc)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. What decreases your pain? (heat, ice, lying down on left/right side, stretching, exercise, etc)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Is this a result of a work, motor -vehicle or personal injury?  Yes  No

If yes, date of injury/accident: \_\_\_\_\_

Please explain the nature of injury or accident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had a Functional Capacity Evaluation?  Yes  No If yes, when? \_\_\_\_\_

Are you currently on any work restrictions?  Yes  No If yes, what are they and which physician placed you on them? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### SLEEP HISTORY

What time do you go to bed? \_\_\_\_\_ How many hours does it take you before you fall asleep? \_\_\_\_\_

How many times do you wake up at night? \_\_\_\_\_

How many hours of sleep do you get per night? \_\_\_\_\_

How many hours do you require? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Have you taken sleep medications or natural supplements to help you fall asleep?  Yes  No

If yes, please list: \_\_\_\_\_

Night time pain:  Yes  No If yes, how severe:  Mild  Moderate  Severe

**FUNCTIONAL HISTORY**

Do you require assistance:  Driving  Walking  Standing  Stairs  Lifting  Cooking  Bathing  
 Toilet  Dressing  Shopping  Ambulating  Household chores (Laundry, dishes, vacuuming, etc)  
 Outdoor yard work (mowing grass, trimming, raking, gardening)

**PAST MEDICAL HISTORY**

Other Treatment

Please list all physicians, chiropractors, massage, therapists and emergency room physicians you have seen for your problem.(Use other side if additional space is needed).

PCP NAME: \_\_\_\_\_

PHONE # \_\_\_\_\_

**PROVIDER SEEN**

**SPECIALTY**

**RELIEF**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check all conditions that you have been diagnosed with:

- |  |   |
|--|---|
| <input type="checkbox"/> Hypertension                            | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Heart Attack or other Cardiac Condition |   |
| <input type="checkbox"/> DVT (blood clots)                       | <input type="checkbox"/> COPD               |
| <input type="checkbox"/> Arthritis                               | <input type="checkbox"/> Fibromyalgia       |
| <input type="checkbox"/> HIV/AIDS                                | <input type="checkbox"/> Lupus              |
| <input type="checkbox"/> Multiple Sclerosis                      | <input type="checkbox"/> Crohn's Disease    |
| <input type="checkbox"/> Suicidal Ideation                       | <input type="checkbox"/> Schizophrenia      |
| <input type="checkbox"/> Depression                              | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Alzheimer's                             | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Diabetes                                | <input type="checkbox"/> Epilepsy           |

**PROVIDER NOTES**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies  No Known Allergies

Latex Allergy  IVP Dye Allergy  Iodine Allergy  Shellfish Allergy  Sulfa Allergy  PCN

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS**

List all medications you currently take (prescription & non-prescription-including aspirin, Tylenol, etc.) Use reverse side if more space is needed.

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Date Started</u>	<u>Prescribing MD/DO</u>
1) _____				
2) _____				
3) _____				
4) _____				
5) _____				
6) _____				
7) _____				
8) _____				
9) _____				

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

10) \_\_\_\_\_

**PREVIOUS PAIN MEDICATIONS/NATURAL SUPPLEMENTS**

**EFFECTIVE**

- 1) \_\_\_\_\_  Yes  No
- 2) \_\_\_\_\_  Yes  No
- 3) \_\_\_\_\_  Yes  No
- 4) \_\_\_\_\_  Yes  No
- 5) \_\_\_\_\_  Yes  No

Previous hospitalizations without surgery (include physician's name)

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

**PAST SURGICAL HISTORY**

Previous surgeries by other physicians (include year and physician's name)

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

Please list all procedures you have had for the pain. Please include year and provider's name.

Chiropractor \_\_\_\_\_  Physical Therapy: # times per week \_\_\_\_\_ when was your last visit \_\_\_\_\_

Massage: # times per week \_\_\_\_\_ when was your last visit \_\_\_\_\_

Interventional Procedures (Epidural injection, Facet Injections, etc.)

**RELIEF**

**HOW LONG DID RELIEF LAST**

- |       |  |       |
|-------|--|-------|
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

**FAMILY MEDICAL HISTORY**  No Problems

(Answers should be mom, dad, brother, sister, aunt, uncle, etc.)

- |  |   |  |
|--|---|--|
| 1. <input type="checkbox"/> Arthritis _____          | 9. <input type="checkbox"/> High Blood Pressure _____ | 17. <input type="checkbox"/> HIV _____     |
| 2. <input type="checkbox"/> Fibromyalgia _____       | 10. <input type="checkbox"/> Heart Attack _____       | 18. <input type="checkbox"/> Cancer: _____ |
| 3. <input type="checkbox"/> Lupus _____              | 11. <input type="checkbox"/> Heart Disease _____      | location: _____                            |
| 4. <input type="checkbox"/> Multiple Sclerosis _____ | 12. <input type="checkbox"/> Diabetes _____           | Relationship: _____                        |
| 5. <input type="checkbox"/> Epilepsy _____           | 13. <input type="checkbox"/> Bronchial Asthma _____   | location: _____                            |
| 6. <input type="checkbox"/> Depression _____         | 14. <input type="checkbox"/> Bleeding Disorder _____  | Relationship: _____                        |
| 7. <input type="checkbox"/> Schizophrenia _____      | 15. <input type="checkbox"/> Hepatitis _____          | location: _____                            |
| 8. <input type="checkbox"/> Alcoholism _____         | 16. <input type="checkbox"/> Thyroid Disorders _____  | Relationship: _____                        |

**SOCIAL HISTORY**

**SMOKING:**

Do you smoke now?  No  Yes Smoking since? \_\_\_\_\_

How many cigarettes per day? \_\_\_\_\_ Cigars per day? \_\_\_\_\_ Pipe? \_\_\_\_\_

Have you ever smoked?  No  Yes Explain \_\_\_\_\_

**ALCOHOL:**

Do you drink alcohol?  No  Yes if yes, how much? \_\_\_\_\_

Have you ever had problems with alcohol?  No  Yes If yes, explain \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**CAFFEINATED DRINKS:**

Do you consume drinks with caffeine?  No  Yes If yes,  Coffee  Tea  Iced Tea  Colas

**DRUGS:**

Do you use any street drugs?  No  Yes If yes, explain \_\_\_\_\_

**MARITAL STATUS:**

Single  Married  Divorced  Widowed # of children: \_\_\_\_\_

**OTHER:**

Have you ever been convicted of a crime?  Yes  No If yes, what was the nature of the offense leading to conviction? \_\_\_\_\_ How recently was such offense? \_\_\_\_\_

**WORK HISTORY**

**CURRENTLY AT WORK:**  Employed  Full Time  Part Time  Self Employed

Occupation: \_\_\_\_\_ What shift do you work? \_\_\_\_\_

How many hours/day? \_\_\_\_\_ How many days/week? \_\_\_\_\_

Describe Job Duties: \_\_\_\_\_

How long do you:  Stand-# hours \_\_\_\_\_  Sit-# hours \_\_\_\_\_  Walk-# hours \_\_\_\_\_

Bend-# hours \_\_\_\_\_  Computer work-# hours \_\_\_\_\_

Do you lift?  Yes  No If yes, how much weight? \_\_\_\_\_ lbs how many repetitions? \_\_\_\_\_ per day

**CURRENTLY NOT AT WORK:**  Unemployed  Retired  Disability  Other Specify: \_\_\_\_\_

Last Date of Employment: \_\_\_\_\_

**LITIGATION HISTORY**

Open Case  Work-related  Personal Injury

Claim # : \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Name of Adjuster/Case Manager: \_\_\_\_\_

Working with attorney

Name of Attorney: \_\_\_\_\_

Firm Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

**H. REVIEW OF SYSTEMS**

<p><b>1. Constitutional Symptoms</b> <input type="checkbox"/> No Problems</p> <p><input type="checkbox"/> Weight loss _____ lbs., during _____</p> <p><input type="checkbox"/> Weight gain _____ lb., during _____</p> <p><input type="checkbox"/> Recurrent Fever <input type="checkbox"/> General weakness <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Chills <input type="checkbox"/> Insomnia <input type="checkbox"/> Hypersomnolence</p>	<p><b>PROVIDER NOTES</b></p>
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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

<p><b>2. Neurological</b> <input type="checkbox"/> No Problems</p> <p><input type="checkbox"/> Incontinence of urine or stool</p> <p><input type="checkbox"/> Frequent or recurrent headaches <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Blackouts <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Gait difficulties</p> <p><input type="checkbox"/> Paralysis <input type="checkbox"/> Frequent Falls</p> <p><input type="checkbox"/> Tremors <input type="checkbox"/> Neuropathy <input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Seizures <input type="checkbox"/> Epilepsy <input type="checkbox"/> Polio</p> <p><input type="checkbox"/> Dizzy Spells <input type="checkbox"/> Vertigo <input type="checkbox"/> Ataxia <input type="checkbox"/> Paresthesia</p> <p><input type="checkbox"/> Problems with concentration <input type="checkbox"/> Hyperesthesia <input type="checkbox"/> Dysarthria</p> <p><input type="checkbox"/> Problems with thinking or thought process</p> <p><input type="checkbox"/> Problems with memory <input type="checkbox"/> Confusion</p>	
<p><b>3. Psychiatric</b> <input type="checkbox"/> No Problems</p> <p><input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Depressed <input type="checkbox"/> Anxious <input type="checkbox"/> Shaky</p> <p><input type="checkbox"/> Agitated <input type="checkbox"/> Obsessive Compulsive Disorder</p> <p><input type="checkbox"/> Post Traumatic Stress Disorder <input type="checkbox"/> Sexual Abuse History</p> <p><input type="checkbox"/> Domestic Violence <input type="checkbox"/> Previous suicide attempts</p> <p><input type="checkbox"/> Panic Episode <input type="checkbox"/> Paranoia <input type="checkbox"/> Hallucinations</p> <p><input type="checkbox"/> Crying Spells <input type="checkbox"/> Mood Swings <input type="checkbox"/> Nervousness</p> <p>Have you had any previous hospitalizations for psychiatric care or treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>History of substance abuse or rehab? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p><b>4. NSAIDS/Anti-Inflammatory</b> <input type="checkbox"/> None (List name, frequency, dosage. ie, Advil, Ibuprofen, Celebrex, etc)_____</p> <p>_____</p>	
<p><b>5. Blood Thinners</b> <input type="checkbox"/> None (List name, frequency, dosage. ie, Coumadin, Aspirin, Excedrin, Vitamin E, Plavix, garlic etc)</p> <p>_____</p> <p>_____</p> <p>_____</p>	<b>PROVIDER NOTES</b>
<p><b>6. Hematologic</b> <input type="checkbox"/> No Problems</p> <p><input type="checkbox"/> Blood transfusion <input type="checkbox"/> Bleeding Disorders (Hemophilia)</p> <p><input type="checkbox"/> Anemia (Iron Deficiency, Pernicious, Sickel cell)</p> <p><input type="checkbox"/> Easy Bruising <input type="checkbox"/> IV Drug Use <input type="checkbox"/> Enlarged Lymph Nodes</p>	
<p><b>7. Infectious Disease</b> <input type="checkbox"/> No Problems</p> <p><input type="checkbox"/> Hepatitis-<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C</p> <p><input type="checkbox"/> HIV <input type="checkbox"/> Herpes <input type="checkbox"/> Shingles <input type="checkbox"/> TB (Tuberculosis)</p>	

<p><b>8. Musculoskeletal</b> <input type="checkbox"/> <b>No Problems</b></p> <p><input type="checkbox"/> Muscle cramps <input type="checkbox"/> Stiff joints _____</p> <p><input type="checkbox"/> Swelling of joints <input type="checkbox"/> Generalized arthritis</p> <p><input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Fibromyalgia syndrome</p> <p><input type="checkbox"/> Osteoporosis <input type="checkbox"/> Neck pain <input type="checkbox"/> Upper back pain</p> <p><input type="checkbox"/> Low back pain <input type="checkbox"/> Heel spur(s) how many _____</p> <p><input type="checkbox"/> Joint Pain <input type="checkbox"/> Hardware <input type="checkbox"/> Deformity</p> <p><input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Crepitation</p> <p><input type="checkbox"/> Gout <input type="checkbox"/> Difficulty with walking <input type="checkbox"/> Pain in feet</p> <p><input type="checkbox"/> Cold upper extremity(ies) <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> Cold lower extremity(ies) <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> Dorsal Column Stimulator <input type="checkbox"/> Intrathecal Pump</p>	
<p><b>9. Cardiac Cardiac/Peripheral-Vascular</b></p> <p><b>i. Cardiac</b> <input type="checkbox"/> <b>No Problems</b></p> <p><input type="checkbox"/> Heart trouble <input type="checkbox"/> Swelling of feet <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart Failure <input type="checkbox"/> Stents</p> <p><input type="checkbox"/> Shortness of breath w/ walking <input type="checkbox"/> Arterial Graft <input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Orthopnea</p> <p><input type="checkbox"/> PND (Paroxysmal Nocturnal Dyspnea) <input type="checkbox"/> Edema</p> <p><input type="checkbox"/> Cyanosis <input type="checkbox"/> Palpitations <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> _____</p> <p><b>ii. Peripheral-Vascular</b> <input type="checkbox"/> <b>No Problems</b></p> <p><input type="checkbox"/> Thrombophlebitis (Inflamed Veins)</p> <p><input type="checkbox"/> Poor circulation in arms <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> Blood clots in arms <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> Varicose veins <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> Poor circulation in legs <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> Blood clots in legs <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> Vascular surgery <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> _____</p>	
<p><b>10. Gastrointestinal</b></p> <p><input type="checkbox"/> IBS(Irritable Bowel Syndrome) <input type="checkbox"/> Crohn's (Ulcerative Cholitis)</p> <p><input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Chronic use of laxatives</p> <p><input type="checkbox"/> Eating Disorder (Anorexia, Bulimia, etc)</p> <p><input type="checkbox"/> Heartburn <input type="checkbox"/> Heart burn <input type="checkbox"/> Jaundice <input type="checkbox"/> Melena</p> <p><input type="checkbox"/> Frequent Bowel Movements <input type="checkbox"/> Change in Bowel Habits</p> <p><input type="checkbox"/> Hematochezia <input type="checkbox"/> Clay Color Stool <input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Rectal Discharge</p>	
<p><b>11. Endocrine</b> <input type="checkbox"/> <b>No Problems</b></p> <p><input type="checkbox"/> Diabetes Insulin Dependent</p> <p><input type="checkbox"/> Goiter <input type="checkbox"/> Hot/Cold Tolerance <input type="checkbox"/> Excessive sweating</p> <p><input type="checkbox"/> Polyuria <input type="checkbox"/> Polydipsia <input type="checkbox"/> Polyphagia <input type="checkbox"/> Infertility</p> <p><input type="checkbox"/> Thyroid Disorder</p>	

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

<p><b>12. Respiratory</b> <input type="checkbox"/> <b>No Problems</b></p> <p><input type="checkbox"/> Cough <input type="checkbox"/> Sputum <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Wheezing <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pleurisy <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> CPAP at Night</p> <p><b>13. Other</b> <input type="checkbox"/> <b>No Problems</b></p> <p><input type="checkbox"/> Cancer Specify _____ <input type="checkbox"/> Rashes, scars _____</p>	
<p><b>14. Procedure Follow Up (Complete Only if You Had Procedure within the last 15 days)</b></p> <p><input type="checkbox"/> Pain Level Before Procedure _____ <input type="checkbox"/> Pain Level After Procedure _____ <input type="checkbox"/> % Pain Relief from Procedure _____ % <input type="checkbox"/> # Days Relief Lasted _____</p> <p>Problems Encountered after Procedure _____ _____</p>	

**RADIOLOGICAL TESTS**

Which of the following tests have been performed? Mark only applicable tests and dates if known.

- i.  Regular X-Rays of \_\_\_\_\_
- ii.  CT Scan of \_\_\_\_\_
- iii.  Myelogram of \_\_\_\_\_
- iv.  MRI of \_\_\_\_\_
- v.  Discogram of \_\_\_\_\_
- vi.  Bone Scan of \_\_\_\_\_
- vii.  Nerve Conduction of \_\_\_\_\_
- viii.  Other, specify \_\_\_\_\_

**TREATMENT GOAL(S):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CERTIFICATION**

I certify that I have answered truthfully all the questions, and have not knowingly withheld any information concerning any of the above problems, either past or present.

Patient Signature: \_\_\_\_\_ Date : \_\_\_\_\_

Transcriber: \_\_\_\_\_ Reviewing Provider(s): \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## PAIN DRAWING ASSESSMENT

**Carefully** draw the location of your pain on the body outlines below. Include **ALL** areas of pain and radiation of pain. Use the following symbols:

Ache=Z

Burning=B

Numbness=X

Pins & Needles=+

Stabbing=/

