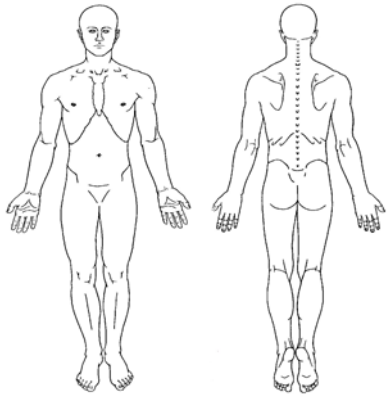
CONSULTANTS IN PAIN MEDICINE

CHECKOUT: (FOR OFFICE USE ONLY)
REFERRALS SENT: YES OR NO (REFERRAL INFORMATION MUST BE GIVEN TO PATIENT)
FOLLOW APPOINTMENT/INJECTION SCHEDULED: YES OR NO
PATIENT SIGNATURE:_____**MA SIGNATURE**:_____



Name:_____
DOB:_____
Height: _____ Weight:_____
Pharmacy:_____
Address/Phone #'s, insurance change? _____

1. Do you get any benefit from current narcotics? (Circle one) Yes or no
2. **Bowel/Bladder incontinence:** yes or no
3. **How long have you had your pain for?**

_____
4. **Pain level Today** (circle one) 0 1 2 3 4 5 6 7 8 9 10
5. **Pain Quality**: Sharp shooting Burning electrical dull aching throbbing constant stabbing
6. **Frequency of Episodes:** (circle one) hourly daily weekly monthly yearly
7. **Severity:** Mild Moderate Severe
8. **Exacerbating Factors**: (activity walking lying down sitting standing)

_____
9. **Does pain Limit your activities:** (circle one) Mildly Limits , Moderate Limits , Severely Limits, doesn't not limit activities.
10. **Alleviating Factors:** (medication, rest)_____
11. **Quality of sleep:** Fair Good Poor
12: **Overall Benefit:** Mild Benefit Moderate Benefit Significant Benefit
13: **Benefit from last injection:** 50%, 75%, 100%
14. **Any interval changes since last visit** (surgeries, hospital visits, medication changes)

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PLEASE CIRCLE ALL THAT APPLY

FEVER	COUGHING
CHILLS	WHEEZING
FATIQUE	VOMITING/NAUSEA
WEIGHT GAIN	CONSTIPATION
WEIGHT LOSS	DIARRHEA
CHEST PAIN	ACID REFLUX/HEARTBURN
DIZZINESS	WEAKNESS
PALPITATIONS	ANXIETY/DEPRESSION/STRESS
SWELLING OF FEET/ANKLES	SUICIDAL THOUGHTS