Pain Treatment and Management

Dr. Stephen Ford

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Please be aware that no medications of any kind will be prescribed on the first visit with Dr. Ford.

Patient Demographics **SSN:** _____

Legal Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (H) _____ (C) _____ Employer: _____

Ethnicity/Race: _____ Sex: Male ☐ Female ☐ Marital Status: _____

Primary Doctor: _____ Referring Doctor: _____

Preferred Language(s): _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Insurance: _____ ID #: _____

Policy Holder, if not patient: _____ DOB: _____ SSN: _____

Secondary Insurance: _____ ID #: _____

Policy Holder, if not patient: _____ DOB: _____ SSN: _____

If the patient is under 18 years old, please fill out information regarding parent/guardian accompanying minor child.

Name: _____ Relationship: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Pain History

Chief Complaint (Reason for your visit today)? _____

Onset of Symptoms

When did your symptoms begin? _____

What caused your current pain episode? _____

Since your pain began how has it changed? Circle one: Improved Worsened No change

How often do you have pain? Circle one: Constantly Frequently Intermittently Occasionally

Describe your pain (circle as many as needed): burning, cutting, sharp, throbbing, cramping, numb, dull, aching, pressure, pins and needles, shooting, electric-like, other _____

Rate your **present** pain on a scale of 0 (no pain) to 10 (worst pain of your life) _____

Rate your pain at its **worst** on a scale of 0 (no pain) to 10 (worst pain of your life) _____

Rate your pain at its **best** on a scale of 0 (no pain) to 10 (worst pain of your life) _____

Pain Intensity

0 I can tolerate the pain I have without having to use pain medication

1 The pain is bad, but I can manage without having to take pain medication.

2 Pain medication provides me with complete relief from pain.

3 Pain medication provides me with moderate relief from pain.

4 Pain medication provides me with little relief from pain.

5 Pain medication has no effect on my pain.

Personal Care

0 I can take care of myself normally without causing increased pain.

1 I can take care of myself normally, but it increases my pain.

2 It is painful to take care of myself, and I am slow and careful.

3 I need help, but I am able to manage most of my personal care.

4 I need help every day in most aspects of my care.

5 I do not get dressed, I was with difficulty, and I stay in bed.

Lifting

0 I can lift heavy weights without increased pain.

1 I can lift heavy weights, but it causes increased pain.

2 Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).

3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.

4 I can only lift light weights, at the most.

5 I cannot lift or carry anything at all.

Walking

0 Pain does not prevent me from walking any distance.

1 Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km)

2 Pain prevents me from walking more than 1/2 mile.

3 Pain prevents me from walking more than 1/4 mile.

4 I can only walk using a cane or crutches.

5 I am in bed most of the time and have to crawl to the toilet

Sitting

0 I can in any chair as long as I like without pain.

1 I can only sit in my favorite chair as long as I like.

2 Pain prevents me sitting more than 1 hour.

3 Pain prevents me sitting more than 1/2 hour.

4 Pain prevents me sitting more than 10 minutes.

5 Pain prevents me from sitting at all.

Standing

0 I can stand as long as I want without increased pain.

1 I can stand as long as I want, but it increases my pain.

2 Pain prevents me from standing for more than 1 hour.

3 Pain prevents me from standing for more than 1/2 hour.

4 Pain prevents me from standing for more than 10 min.

5 Pain prevents me from standing at all.

Sleeping

0 Pain does not prevent me from sleeping well.

1 I can sleep well only by using pain medication.

2 Even when I take medication, I sleep less than 6 hours.

3 Even when I take medication, I sleep less than 4 hours.
4 Even when I take medication, I sleep less than 2 hours.
5 Pain prevents me from sleeping at all.

Social Life

0 My social life is normal and does not increase my pain.
1 My social life is normal, but it increases my level of pain.
2 Pain prevent me from participating in more energetic interests, (e.g., dancing, sports.
3 Pain prevents me from going out very often.
4 Pain has restricted my social life to my home.
5 I have hardly any social life because of the pain.

Traveling

0 I can travel anywhere without increased pain.
1 I can travel anywhere, but it increases my pain.
2 My pain restricts my travel over 2 hours.
3 My pain restricts my travel over 1 hour.
4 My pain restricts my travel to short necessary journeys under 1/2 hour.
5 My pain prevents all travel except for visits to the physician/therapist or hospital.

Diagnostic Tests and Imaging

List all the diagnostic tests and imaging that you have had related to your current pain complaints:_____
_____
_____

Interventional Pain Treatment History

List all the diagnostic tests and imaging that you have had related to your current pain complaints:_____
_____
_____

Previous Pain Treatments

Please check all the treatments you have tried for this pain problem and then complete the appropriate column at the right to the best of your ability.

Treatment	No Change	Worsened Pain	Improved Pain
Spine Surgery			
Physical Therapy			
Chiropractic Care			
Psychological Therapy			
Brace support			
Acupuncture			
Hot/Cold packs			
Massage Therapy			
TENS unit			
Biofeedback			
Spinal cord stimulator			
Intrathecal pump			

Current Medications

Please list all medications you are currently taking including vitamins and supplements. Please do not write "see attached"

Medication Name	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Please list all past pain medications that you have been on at any point for your current pain complaints.

Medication Name	Dose	Frequency	Reason for stopping
1.			
2.			
3.			
4.			
5.			

Only if any of your medications cause constipation, please answer these questions. If not, skip this section.
On average, how often do you have bowel movements? Please check one.

☐ more than 3 times per day ☐ Once per day ☐ Less than once per week

☐ 2 - 3 times per day ☐ 2 – 3 times per week

Think back to when you started pain medicine. Did your bowel habits change? If so, how? _____

Are you currently taking any blood thinners or anti-coagulants? ☐ Yes ☐ No

If yes, which ones? ☐ Aspirin ☐ Coumadin ☐ Plavix ☐ Lovenox ☐ Other _____

Have you been given /prescribed a form of Narcan to use in case of emergency? ☐ Yes ☐ No

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medication allergies:

Medication Name	Reaction (anaphylaxis, hives, itching, etc.)
1.	
2.	
3.	
4.	
5.	

PHQ 9

How often have you been bothered by the following over the past two weeks?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things?				
Feeling down, depressed, or hopeless?				
Trouble falling or staying asleep, or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself or that you are a failure or have let yourself or your family down?				
Trouble concentrating on things, such as reading the newspaper or watching television?				
Moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual?				
Thoughts that you would be better off dead or thoughts of hurting yourself in some way?				

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past. Please check all that apply.

Cancer/Oncology Type (List all active)	✓	**Neurological**	✓	**Psychological**	✓
1.		Multiple Sclerosis		Depression	
2.		Peripheral Neuropathy		Anxiety	
3.		Seizures		Schizophrenia	
Cardiovascular/Hematologic		Balance Disorder		Bipolar Disorder	
Anemia		Head Injury		ADD/ADHD	
Heart Attack		Headaches		PTSD	
Coronary Artery Disease		Migraines		**Urological**	
High Blood Pressure		**Respiratory**		Chronic Kidney Disease	
Peripheral Vascular Disease		Asthma		Kidney Stones	
Stroke/TIA		Bronchitis/Pneumonia		Urinary Incontinence	
Heart Valve Disorders		Emphysema/COPD		Dialysis	
Presence of stent/pacemaker/defibrillator		**Musculoskeletal/Rheumatologic**		**ENT**	
Gastrointestinal		Bursitis		Glaucoma	
GERD		Carpal Tunnel Syndrome		Vertigo	
Gastrointestinal Bleeding		Fibromyalgia		Hearing Problems	
Stomach Ulcers		Osteoarthritis		Nosebleeds	
IBS/Crohn's Disease		Rheumatoid Arthritis		**Endocrinology**	
		Chronic Joint Pains		Diabetes – type _____	
Other Diagnosed Conditions:				Hyperthyroidism	
				Hypothyroidism	

Past Surgical History

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

☐ I have NEVER had any surgical procedures performed.

Family History

☐ Arthritis ☐ High blood pressure ☐ Rheumatoid arthritis
☐ Headaches/Migraines ☐ Osteoporosis ☐ Other: _____
☐ Liver problems ☐ Stroke _____
☐ Seizures ☐ Diabetes _____
☐ Cancer ☐ Kidney problems _____

Social History

Occupation: _____ When was the last time you worked? _____
Are you currently under worker's compensation? ☐ Yes ☐ No
Is there an ongoing lawsuit related to your visit today? ☐ Yes ☐ No
Alcohol Use: ☐ Social use ☐ Daily use of alcohol ☐ Never ☐ History of alcoholism ☐ Current alcoholism
Tobacco Use: ☐ Current user ☐ Former user ☐ Never used
Illegal Drug Use: ☐ Denies any drug use ☐ Currently uses illegal drugs ☐ Formerly used illegal drugs (not current)
Marijuana Use: ☐ Yes ☐ No
Have you ever abused narcotic prescription medications? ☐ Yes ☐ No

Review of systems

Mark the following symptoms that you currently suffer from:

CONSTITUTIONAL	✓	**EYES**	✓	**GENITOURINARY**	✓
Activity change		Eye discharge		Difficulty urinating	
Appetite change		Eye itching		Dyspareunia (painful intercourse)	
Chills		Eye itching		Dysuria (Painful urination)	
Diaphoresis (sweating)		Eye pain		Enuresis (Bed wetting)	
Fatigue		Eye redness		Flank pain (side pain below the ribs)	
Fever		Photophobia (light sensitivity)		Change in frequency of urination	
Unexpected weight change		Visual disturbances		Genital sore	
HENT		**RESPIRATORY**		Hematuria (blood in urine)	
Facial swelling		Apnea (stop breathing)		Menstrual problem	
Neck pain		Chest tightness		Pelvic pain	
Neck stiffness		Choking		Urgency of urination	
Ear discharge		Cough		Urine decreased	
Hearing loss		Shortness of breath		Vaginal bleeding	
Ear pain		Stridor (high pitched sound when inhaling)		Vaginal discharge/pain	
Tinnitus		Wheezing		**MUSCULOSKELETAL**	
Nosebleeds		**CARDIOVASCULAR**		Arthralgias (joint pain)	
Congestion		Chest pain		Back pain	
Rhinorrhea		Leg swelling		Gait problem	
Postnasal drip		Palpitations		Joint swelling	
Sneezing		**GASTROINTESTINAL**		**SKIN**	
Sinus pressure		Abdominal distention		Color change	
Dental problem		Abdominal pain		Pallor (pale skin)	
Drooling		Anal bleeding		Rash	
Mouth sores		Blood in stool		Wound	
Sore throat		Constipation		**PSYCHIATRIC**	
Trouble swallowing		Diarrhea		Agitation	
Voice change		Nausea		Behavior problem	
NEUROLOGICAL		Rectal pain		Confusion	
Dizziness		Bowel incontinence		Decreased concentration	
Facial asymmetry (drooping)		**HEMATOLOGIC**		Dysphoric mood (feeling uneasy, unwell)	
Headaches		Adenopathy (swollen lymph nodes)		Hallucinations	
Light-headedness		Easy bruising/bleeding		Hyperactive	
Numbness				Nervous/anxious	
Seizures				Self-injury	
Speech difficulty				Sleep disturbance	
Syncope				Suicidal ideas	
Tremors					
Weakness					