

## Korunda Pain Management Center

The following questions are designed to help your physician understand your current pain patterns and past treatment history. If you do not understand any of the following questions, please ask for assistance.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Are you: (please circle) Male / Female      Right-Handed / Left-Handed

Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Other Important Attending Physicians: \_\_\_\_\_

Allergies: \_\_\_\_\_

List of Medications: (include dosage and when taken)

\_\_\_\_\_

\_\_\_\_\_

Are you currently taking any blood thinners? Yes / No

What are you taking? Coumadin, Lovenox, Aspirin, Plavix, Ticlid, Heparin, Other: \_\_\_\_\_

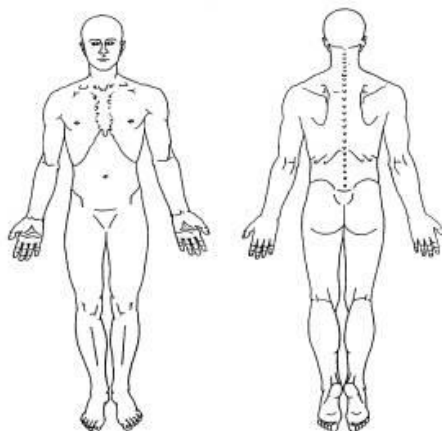
How long have you been taking the medication? \_\_\_\_\_

Why were you put on this medication? \_\_\_\_\_

Which doctor is monitoring this medication use? \_\_\_\_\_ Phone number? \_\_\_\_\_

### Pain History:

Pain Diagram: Please shade the areas of the diagram that correlate with your current pain location.



In your own words, describe your pain: \_\_\_\_\_

Please circle all of the following that describe the character of your pain:

Constant, Brief, Intermittent, Sharp, Dull, Deep, Superficial, Stabbing, Radiating, Tingling, Burning, Aching, Shooting, Spasms, Numbness, Other not listed: \_\_\_\_\_

How long have you had this pain? \_\_\_\_\_

On a Pain Scale of 0 -10 (0 = none and 10 = worse pain of your life) what is your pain level today?

0 1 2 3 4 5 6 7 8 9 10

- Please turn over -

Is today a typical pain level or is this one of your good day/bad days? Good / Bad / Typical  
 What is your pain level on a bad day, if different from above? 0 1 2 3 4 5 6 7 8 9 10

Is the pain a result of an injury or trauma? Yes / No

If so explain: \_\_\_\_\_

What time of the day is your pain worst? \_\_\_\_\_ The least? \_\_\_\_\_

What makes the pain better? \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

Of the following, which medications have you tried for pain relief if any? (please circle)

Lyrica / Cymbalta / Neurontin          Ultram / Ultracet / Tramadol

Lidoderm / Flector Patches          Baclofen / Flexeril / Arthrotec / Mobic / Celebrex

Percocet / Lortab / Vicodin / Oxycontin / Methadone / Ms Contin / Dilaudid / Fentanyl

Tylenol / Advil / Ibuprofen / Aleve      Other not listed: \_\_\_\_\_

### Imaging:

**MRI** (Magnetic Resonance Imaging) Yes / No      What was imaged? \_\_\_\_\_

Date? \_\_\_\_\_      Location where test performed? \_\_\_\_\_

Do you have copies of the results? Yes / No

**EMG / NCS**(Electromyogram/Nerve Conduction Study) Yes / No      Date? \_\_\_\_\_

Do you have copies of the results? Yes / No      Location where performed? \_\_\_\_\_

**Dexa / Bone Density Scans** Yes/No      Date? \_\_\_\_\_

Do you have copies of the results? Yes / No

Location where performed? \_\_\_\_\_

**CT Scans** (CAT Scans) Yes / No      What was imaged? \_\_\_\_\_ Date? \_\_\_\_\_

Location where performed? \_\_\_\_\_

Do you have copies of the results? Yes / No

**X-Ray** Yes / No      What was imaged? \_\_\_\_\_ Date? \_\_\_\_\_

Location where performed? \_\_\_\_\_

Do you have copies of the results? Yes / No

**Ultrasounds** Yes / No      What was imaged? \_\_\_\_\_ Date? \_\_\_\_\_

Location where performed? \_\_\_\_\_      Do you have copies of the results? Yes / No

Other imaging not listed above? \_\_\_\_\_

### Injections:

Have you had injections done in the past? Yes / No

Trigger Point Injections? Yes / No

Body Location? \_\_\_\_\_ Dates? \_\_\_\_\_ Did it help? Yes / No

Joint/Bursa Injections Yes / No

Joint Location? \_\_\_\_\_ Dates? \_\_\_\_\_ Did it help? Yes / No

## Injections Continued

Epidural Injections? Yes / No    Cervical / Lumbar / Thoracic    Did it help? Yes / No  
 Dates? \_\_\_\_\_ Who did the injection? \_\_\_\_\_

Facet Injections? Yes / No    Cervical / Lumbar / Thoracic    Did it help? Yes / No  
 Dates? \_\_\_\_\_ Who did the injection? \_\_\_\_\_

Radiofrequency Ablation? Yes / No    Cervical / Lumbar / Thoracic    Did it help? Yes / No  
 Dates? \_\_\_\_\_ Who did the procedure? \_\_\_\_\_

Botox Injections? Yes / No    Body Location? \_\_\_\_\_ Did it help? Yes / No  
 Who did the injection? \_\_\_\_\_ Date? \_\_\_\_\_

Other \_\_\_\_\_

Have you tried Physical Therapy? Yes / No    Did it work? Yes / No

Have you tried chiropractics / acupuncture? Yes / No    Did it work? Yes / No

## Past Surgical History (please circle):

Lumbar: Laminectomy / Fusion    Hardware Implant    Vertebro / Kyphoplasty  
 Levels: \_\_\_\_\_ Date: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Cervical: Laminectomy / Fusion    Hardware Implant    Vertebro / Kyphoplasty  
 Levels: \_\_\_\_\_ Date: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Thoracic: Laminectomy / Fusion    Hardware Implant    Vertebro / Kyphoplasty  
 Levels: \_\_\_\_\_ Date: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Abdominal: Appendectomy / When? \_\_\_\_\_ Gall Bladder / When? \_\_\_\_\_  
 Hysterectomy / When? \_\_\_\_\_ Colectomy / When? \_\_\_\_\_  
 Other Abdominal: \_\_\_\_\_

Orthopedic: Knee: L / R Date: \_\_\_\_\_    Repair / Replacement  
 Hip: L / R Date: \_\_\_\_\_    Repair/Replacement  
 Shoulder: L / R Date: \_\_\_\_\_    Repair/Replacement  
 Carpal Tunnel Release: L / R Date: \_\_\_\_\_  
 Other Orthopedic: \_\_\_\_\_

## Past Medical History (please circle all that apply to your health)

### Cardiac:

Hypertension, Heart Attack, Chest pain, Heart Failure, Pacemaker, Irregular Rhythm,  
 Other: \_\_\_\_\_

### Gastro-Intestinal:

Hernia, Ulcers, Gastritis, Pancreatitis, GERD, IBS, Diverticulitis, Colitis, Hepatitis,  
 Other: \_\_\_\_\_

Immune/Endocrine: Diabetes, Tuberculosis, Cancer, Thyroid, Arthritis, Fibromyalgia,  
 Rheumatologic, Other: \_\_\_\_\_

### Respiratory:

COPD, Asthma, Chronic Cough or Lung Disease, Emphysema,  
 Other: \_\_\_\_\_

### Neurological:

Headaches, Seizures, Stroke/TIA, Head Injury, Epilepsy, Sleeping problems, Other: \_\_\_\_\_

- Please turn over -

**ENT:**

Eye disorders, Ear disorders, Nasal disorders, Throat disorders, Other: \_\_\_\_\_

**Urological:**

Kidney disease, Urinary/Bladder infections, Incontinence, Prostatitis, Prostate cancer,  
Other: \_\_\_\_\_

**Musculoskeletal:**

Abnormal muscle function, Loss of Joint Function, Spine/Joint pain, Arthritic pain, Joint replacement,  
Generalized aches/pain, Other: \_\_\_\_\_

**Hematological:**

Bleeding disorder, Inability to control bleeding from cuts, Phlebitis/blood clots, Transfusions,  
Immune problems/HIV/AIDs, Other: \_\_\_\_\_

**Social History:** (Please Circle)

Residence: Full time/Seasonal

Hobbies: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Staus: \_\_\_\_\_ Children: \_\_\_\_\_

Do you receive Disability Compensation: Yes/No    Recent stressful events: Yes/No

Currently or considering Legal action involving your pain: Yes/No

Tobacco use: Current, Never, or Past History of use

Alcohol use: Current, Never, or Past History of use

Recreational drugs: Current, Never, or Past History of use

Psychiatric history: Current/Past Treating Physician: \_\_\_\_\_

**Family History** (circle all positive family history):

Mothers Health:    Alive and Well /Chronic Illness /Deceased

Cause of death: \_\_\_\_\_

Fathers Health:    Alive and Well /Chronic Illness /Deceased

Cause of death: \_\_\_\_\_

**Other Significant Past Family History:**

Cancer, Hypertension, Asthma, Stroke, Lung diseases, Epilepsy/Seizures, Bleeding disorders,  
Diabetes, Hearth disease, Neuromuscular disease, Colitis, Rheumatic heart disease, Depression,  
Angina, Kidney stones, Circulatory problems, Arthritis, and history of suicide attempt/success.

**Are currently experiencing any of the following:**

Sudden weight loss, changes in sleep pattern, panic attacks, loss of appetite, loss of energy,  
anxiousness, chest pain or depression

**Thank you for taking the time to fill this new patient form out. This information will help us in offering you a more comprehensive evaluation and treatment plan.**