Pain Management Intake

Pain History:

Chief Complaint (reason for visit):

_____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain:

_____

Onset of Symptoms:

When did the pain approximately begin? _____

What caused your current pain episode and did it begin gradually / suddenly?

_____

How has your pain changed since it began? Improved / Worsened / Stayed the same

Pain Description:

- ☐ Dull / Aching
- ☐ Cramping
- ☐ Squeezing
- ☐ Hot/Burning
- ☐ Numbness / Tingling
- ☐ Sharp/Shooting / Stabbing
- ☐ Throbbing / Tightness

When is your pain at its worst?

- ☐ Mornings
- ☐ Evenings
- ☐ Always the same
- ☐ Mid-day
- ☐ Middle of the night

How often is pain occurring?

- ☐ Constantly
- ☐ Changes in severity, but always present
- ☐ Comes and goes

On a scale from 0-10, where would you rate your pain level? No pain = 0, The worst pain imaginable = 10

Right now_____ The best it gets _____ The worst it gets _____

Which of the following affects your pain level?

- ☐ **Bending forward/backward**: Increases / Decreases / No Change
- ☐ **Changes in weather**: Increases / Decreases / No Change
- ☐ **Stairs**: Increases / Decreases / No Change
- ☐ **Coughing/Sneezing**: Increases / Decreases / No Change
- ☐ **Driving**: Increases / Decreases / No Change
- ☐ **Lifting**: Increases / Decreases / No Change
- ☐ **Looking up/down**: Increases / Decreases / No Change
- ☐ **Rising from seat**: Increases / Decreases / No Change
- ☐ **Sitting**: Increases / Decreases / No Change
- ☐ **Standing**: Increases / Decreases / No Change
- ☐ **Walking**: Increases / Decreases / No Change

What are some alleviating factors for your pain?

- ☐ Heat/Ice
- ☐ Sitting
- ☐ Standing
- ☐ Lying down
- ☐ Rest
- ☐ Stretching
- ☐ Exercise
- ☐ Medication
- ☐ Rest
- ☐ Nothing

Associated Symptoms

- ☐ Numbness/Tingling
- ☐ Weakness in the arm/leg
- ☐ Balance Problems
- ☐ Bladder Incontinence
- ☐ Bowel incontinence
- ☐ Joint Swelling/Stiffness
- ☐ Fever/Chills

Mark the following physicians or specialists you have consulted for your current pain problem(s) and if they were effective/ineffective:

- ☐ Acupuncturist : Effective/Ineffective
- ☐ Chiropractor: Effective/Ineffective
- ☐ Physical Therapist: Effective/Ineffective
- ☐ Neurosurgeon/Doctor: Effective/Ineffective
- ☐ Orthopedic Surgeon/Doctor: Effective/Ineffective
- ☐ Rheumatologist: Effective/Ineffective
- ☐ Internist: Effective/Ineffective
- ☐ Other: _____ : Effective/Ineffective

Interventional Pain Treatment History:

- ☐ Epidural Steroid injection
- ☐ Joint Injection(s): which joint?_____
- ☐ Medial Branch Blocks/Facet Injection (circle level) - Cervical / Thoracic / Lumbar
- ☐ Nerve Block - Area/Nerve? _____
- ☐ Radiofrequency Nerve Ablation (circle level) - Cervical / Thoracic / Lumbar
- ☐ Spinal Cord Stimulator (circle one) - Trial / Permanent Implant
- ☐ Trigger point injections - Where? _____
- ☐ Vertebroplasty/Kyphoplasty (circle level) - Cervical / Thoracic / Lumbar
- ☐ Other: _____

Which of the above procedures have **helped** with your pain?

_____

Have you had any diagnostic testing for the current pain problem?

- ☐ MRI
- ☐ X-Ray
- ☐ CT Scan
- ☐ EMG (Nerve Conduction Study)
- ☐ Other: _____
- ☐ I have not had ANY diagnostic tests for my current pain issue

What facility? _____

***Date of last/future Mammogram:** _____

***Date of last/future DEXA Scan (bone density scan):**_____

***Date of last/future Colonoscopy:** _____

Past Surgical History:

Please list any surgical procedures you have had done in the past including the dates:

_____

_____

_____

_____

_____

Past Medical History:

Mark the following conditions/diseases that you have been treated for in the past:

General medical:

- ☐ Cancer - Type: _____
- ☐ Diabetes - Type: _____

Cardiovascular/Hematologic:

- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stroke/TIA

Gastrointestinal/Urological:

- ☐ GERD (Acid Reflux)
- ☐ GI Problems
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence

Neuropsychological:

- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Depression/Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder

Head/Ears/Eyes/Nose/Throat:

- ☐ Headaches
- ☐ Migraines
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Glaucoma

Respiratory:

- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Musculoskeletal/Rheumatologic:

- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

Other Diagnosed Conditions:

_____

_____

_____

_____

_____

_____

_____

Current Medications (Please include dosage and how often you take it):

_____ _____

_____ _____

_____ _____

_____ _____

Are you currently taking any Blood Thinning Medication? If so, please select which one:

- ☐ Aspirin
- ☐ Plavix
- ☐ Eliquis
- ☐ Coumadin
- ☐ Lovenox
- ☐ Other: _____

- ☐ **I do not take blood thinning medication**

PLEASE LIST ALL PAST PAIN MEDICATIONS THAT YOU HAVE TRIED AT ANY POINT FOR YOUR CURRENT PAIN ISSUE:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies:

_____ _____

_____ _____

_____ _____

_____ _____

***Any allergies to the following (Circle what applies):** Latex/Contrast Dye/Iodine/Shellfish

Social History:

Occupation: _____

Circle what applies: Temporary Disability / Permanent Disability / Retired / Unemployed

Are you currently under workers compensation or Lien? Yes / No

Is there an ongoing lawsuit related to your visit today? Yes / No

Alcohol Use (circle what applies): Never used/Social use/Daily use/History of alcoholism/Current Alcoholism

Tobacco Use (circle what applies): Never used/Currently using/Former user

If **CURRENT** user, please fill out the following:

*Packs per day: _____

*How long: _____

If **FORMER** user, please fill out the following:

*Quit date: _____

Illegal Drug use: Denies any illegal drug use/**Current** illegal drug user/**Former** illegal drug user

*** Have you ever abused narcotic or prescription medications?** Yes / No

PHQ-2/PHQ-9: Please circle the answers that apply to you:

1. Little interest or pleasure in doing things (Not at all/several days/More than half the days/nearly every day)
2. Feeling down, depressed or hopeless (Not at all/several days/More than half the days/nearly every day)
3. Trouble falling or staying asleep (Not at all/several days/More than half the days/nearly every day)
4. Feeling tired or having little energy (Not at all/several days/More than half the days/nearly every day)
5. Poor appetite or overeating (Not at all/several days/More than half the days/nearly every day)
6. Feeling bad about yourself - or that you are a failure of have let yourself or your family down (Not at all/several days/More than half the days/nearly every day)
7. Trouble concentrating on things, such as reading the newspaper or watching TV (Not at all/several days/More than half the days/nearly every day)
8. Moving or speaking so slowly that people have noticed. Or the opposite - being so fidgety or restless that you move around a lot more (Not at all/several days/More than half the days/nearly every day)
9. Thoughts you would be better off dead or of hurting yourself (Not at all/several days/More than half the days/nearly every day)
10. If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with others? (Not difficult at all/Somewhat difficult/Very difficult/Extremely Difficult)

Review of Systems (check all that apply)

Constitutional:

- ☐ Chills/Fever
- ☐ Night sweats
- ☐ Unexplained weight Gain / Loss
- ☐ Difficulty sleeping
- ☐ Fatigue

Eyes/Ears/Nose/Throat/Neck:

- ☐ Recent Visual Changes
- ☐ Dry Eyes
- ☐ Nosebleeds
- ☐ Sinus Problems
- ☐ Earaches
- ☐ Hearing Problems

Cardiovascular:

- ☐ Chest Pain
- ☐ Fainting
- ☐ Shortness of Breath
- ☐ Palpitations
- ☐ Blood Clots
- ☐ Swelling in feet
- ☐ Heart Murmur
- ☐ Heart Problems

Respiratory:

- ☐ Cough
- ☐ Wheezing
- ☐ Sleep Apnea

Gastrointestinal:

- ☐ Constipation/Diarrhea
- ☐ Acid Reflux
- ☐ Abdominal Cramps
- ☐ Nausea/Vomiting

Musculoskeletal:

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Joint Swelling/Stiffness
- ☐ Joint Pains
- ☐ Muscle Spasms/Cramping

Genitourinary/Nephrology:

- ☐ Flank Pain
- ☐ Blood in Urine
- ☐ Decreased Urine flow/frequency/volume
- ☐ Increased Urine flow/frequency/volume
- ☐ Painful urination
- ☐ Urinary Incontinence

Neurological:

- ☐ Dizziness
- ☐ Headaches/Migraines
- ☐ Numbness/Tingling
- ☐ Tremors
- ☐ Seizures

Psychiatric:

- ☐ Depressed mood
- ☐ Anxiety
- ☐ Anger
- ☐ Suicidal Thoughts
- ☐ Thoughts of harming others/yourself
- ☐ Stress
- ☐ Mood Swings
- ☐ Memory Loss
- ☐ Hallucination

Medical Release Form

Patient Name/DOB: _____

Phone number: _____

Please release my medical records from:

1) Name of Provider/Facility: _____

   Phone number: _____ Fax #:_____

2) Name of Provider/Facility: _____

   Phone number: _____ Fax #:_____

3) Name of Provider/Facility: _____

   Phone number: _____ Fax #:_____

4) Name of Provider/Facility: _____

   Phone number: _____ Fax #:_____

Send to:

Hillside Health

1841 E. Riverside Dr. Suite 201

St. George, UT 84790

Phone: (435)-256-8890 Fax: (833)-907-2388

Patient Signature: _____ Date: _____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

FOR OFFICE USE ONLY **(Please circle what you would like released):**

Progress notes / Clinic notes / History & Physical / Discharge notes / Colonoscopy report Consultations / Operative Reports / Radiology Reports / Lab Results / Pathology Reports Pap Smear Results / Prescriptions / EKG+ECG+EMG / Psych Evaluation / Procedure Notes + reports / Physician Orders / Mammogram Report / **ALL RECORDS**