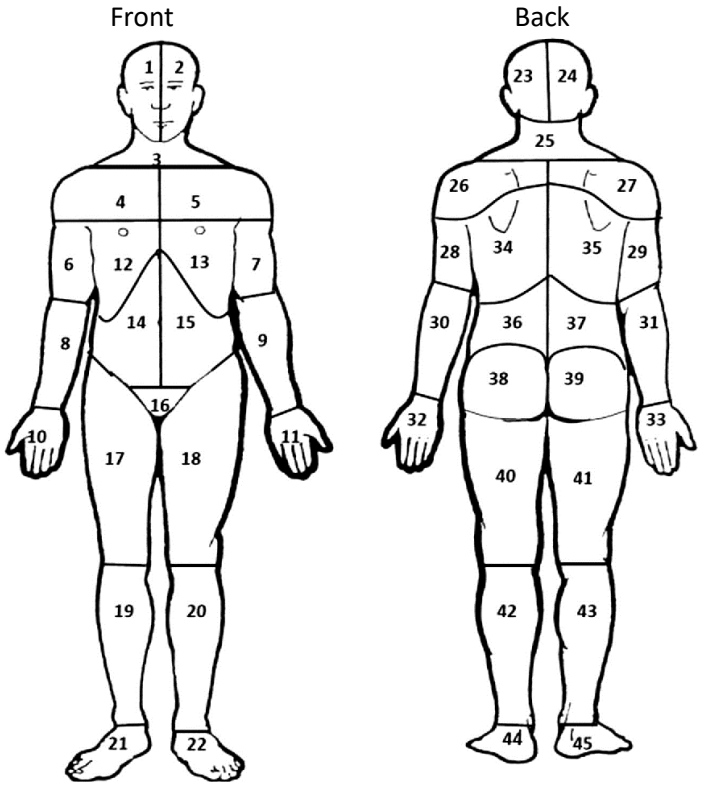
Name: _____ Date of Birth: _____

Tell Us About Your Pain

We understand you may have pain in more than one area. Please, answer the following questions for your **most painful area** or the area you would **most like help with**:

Where is the majority of your pain located?
Please circle the number(s) which best correspond with the location of your pain.



When did this pain first start? Month ____ / Day ____ / Year _____ *(approximate date OK)*

Was the onset of the pain associated with an injury or significant event? *(circle one)* No Yes
If yes, please explain: _____

If this is a long-standing problem, is it worse now than it was before? *(circle one)* No Yes
If yes, when did it significantly worsen? Month ____ / Day ____ / Year _____ *(approximate date OK)*

How often do you experience the pain? (circle one)

Constant *(Always present)* Intermittent *(Comes and goes)*

Please, use the following scale as a reference to answer the next two questions. Consider 10 on this scale as the worst pain you can imagine. Consider 0 as no pain.

How significant is your pain on average? This an average between your best and worst pain: _____

How significant is your pain when it's at its worst? _____

How would you describe the pain? *(circle all that apply)*

Sharp	Dull	Numbness	Tingling
Stabbing	Ache-like	Burning	Pins and needles

Other: _____

What <u>definitely</u> worsens your pain? *(circle all that apply)*

Sitting	Getting dressed	Home maintenance
Moving from sitting to standing	Walking in your home	Driving
Standing	House-cleaning	Light activity
Lying down	Shopping	Moderate activity
Walking	Meal preparation	High intensity activity
Bathing	Bending	

Other: _____

What <u>definitely</u> improves your pain? *(write in)* _____

_____

Have you had imaging for this problem? *(circle all that apply)*

X-ray CT scan MRI Ultrasound Other: _____

What treatments have you tried for this problem?

Physical therapy? *(circle one)* Never Currently Doing Completed _____ *(month/year)*
If completed, are you continuing with home exercises? *(circle one)* No Yes

Chiropractic? *(circle one)* No Yes

Acupuncture? *(circle one)* No Yes

Have you had previous injections for this pain? If so, please complete:

Type of injection: _____ When? _____ *(month/year)*
Type of injection: _____ When? _____ *(month/year)*
Type of injection: _____ When? _____ *(month/year)*
Type of injection: _____ When? _____ *(month/year)*

What medications have you tried for this problem? Please, **circle** all medications tried in the past and **circle & <u>underline</u>** medications you are currently using:

Over-the-Counter Medications

Acetaminophen (Tylenol) Naproxen (Aleve) Aspirin [specifically of pain]

Ibuprofen (Motrin) Excedrin

Topical Medications

Topical diclofenac (Voltaren gel) Lidocaine patches

Topical lidocaine gel or cream Over-the-counter analgesic cream

Non-Steroidal Anti-Inflammatories (NSAIDs)

Meloxicam (Mobic) Celecoxib (Celebrex) Indomethacin (Indocin)

Diclofenac [tablets] Etodolac (Lodine) Ketorolac (Toradol)

Oral Steroids

Medrol Dosepak (Methyprednisolone)	Prednisone

Neuropathic Medications

Gabapentin (Neurontin)	Duloxetine (Cymbalta)	Nortriptyline (Aventyl, Pamelor)
Pregabalin (Lyrica)	Amitriptyline (Elavil)	Carbamazepine (Tegretol)

Muscle Relaxors

Cyclobenzaprine (Flexeril)	Orphenadrine (Norflex)	Baclofen
Tizanidine (Zanaflex)	Methocarbamol (Robaxin)	Carisoprodol (Soma)

Opioid Medications

Tramadol (Ultram)	Oxycodone (Percocet, OxyContin)
Morphine (MS Contin)	Methadone
Hydrocodone (Lortab, Norco, Vicodin)	Fentanyl patch
Buprenorphine (Butrans, Belbuca, Suboxone)	