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Integrated Pain Care
A Pain Management Clinic of Excellence

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INITIAL PAIN QUESTIONNAIRE

Please complete this form today before your first appointment at the Pain Management Center.

Your careful answers will help us to understand your pain problem and design the best treatment program for you

1. Name:_____ Date of Birth: _____ Age: _____ Sex: M F
last, first

2. Referring Doctor _____3. Primary Doctor_____

4. Pain location _____

5. When did you first start having the pain? _/_____/_____(month/day/year)

6. Are your symptoms related to an injury (including repetitive strain injury)? Yes No

7. If yes, the date of the injury was _/_____/_____(month/day/year)

8. Then injury was: ☐ Work related ☐ Motor Vehicle Injury ☐ Falling Injury ☐ Twisting
☐ Not Work Related ☐ Lifting Injury ☐ Repetitive Strain Injury ☐Whiplash

HISTORY OF INJURY: Please describe HOW your pain started in as much detail as possible:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

1. What body parts did you suffer injuries to from this accident?

☐ Head ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Lower Back

☐ Shoulder R L ☐ Arm R L ☐ Elbow R L ☐ Wrist R L ☐ Hand R L

☐ Leg R L ☐ Knee R L ☐ Ankle R L ☐ Foot R L ☐ Other _____

2. Who did you report the injury to after it happened?

☐ Employer ☐ Supervisor ☐ Other _____

3. Did you continue to work your shift?

☐ Yes ☐ No If no, did you go home? ☐ Yes ☐ No

4. If this was a motor vehicle accident: Were you the: ☐ Driver ☐ Passenger

☐ Front seat ☐Back Seat

Were you wearing your seat belt? ☐ Yes ☐ No

Did your airbags deploy? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

5. Where did you go after the injury?

☐ Home ☐ Hospital ☐ Company's Clinic ☐ Other: _____

6. Were you sent to the doctor?

☐ Yes ☐ No If yes, were you sent ☐ the same day ☐ the next day

☐ Other: _____

7. What doctors did you see?

☐ Chiropractor ☐ Orthopedic ☐ General Practitioner ☐ Pain Management Doctor

Other: _____

8. Did you have any diagnostic studies performed? ☐ Yes ☐ No

When? _____

Where? _____

What body part? _____

Previous diagnostic studies (dates and results):

MRI
CT
X-Rays
EMG/NCV
Discography

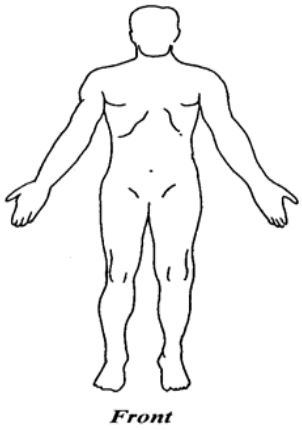
9. What kind of treatment was provided?

Treatment	How many, when and by whom?	Excellent Relief	Moderate Relief	No Relief
☐ Epidural steroid injection		☐	☐	☐
☐ Sacroiliac joint injection		☐	☐	☐
☐ Trigger point injections		☐	☐	☐
☐ Nerve block		☐	☐	☐
☐ Physical Therapy		☐	☐	☐
☐ Exercise		☐	☐	☐
☐ Acupuncture		☐	☐	☐
☐ Chiropractic		☐	☐	☐
☐ TENS		☐	☐	☐
☐ Surgery		☐	☐	☐
☐ Hypnosis		☐	☐	☐
☐ Biofeedback		☐	☐	☐
☐ Psychotherapy		☐	☐	☐
☐ TENS unit		☐	☐	☐
☐ Other:		☐	☐	☐

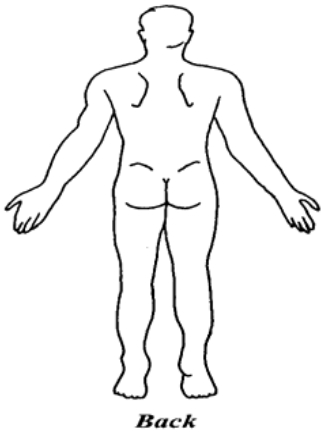
PRESENT COMPLAINTS:

11. Please mark the location(s) of your pain with an "X" and show where it goes with an arrow.
If whole areas are painful, shade in the painful area. Circle the words which best describe you pain.

sharp
cutting
throbbing
dull, aching
pressure
muscle pain
cramping


Front

shooting
electric-
like
pins and
needles
weakness
numbness


Back

burning
skin sensitivity to light touch,
cold abnormal swelling,
hair/nail growth abnormal
sweating
abnormal skin color
changes abnormal skin
temperature limited

1. Are your current pain complaints: ☐ Mild ☐ Moderate or ☐ Severe?

Pain Intensity: Circle your current pain intensity with "0" representing no pain and "10" the most severe pain imaginable.

12a. 0 1 2 3 4 5 6 7 8 9 10
minimal slight moderate severe

12b. Circle your average pain the last 7 days
0 1 2 3 4 5 6 7 8 9 10

12c. Circle your least pain score the last 7 days
0 1 2 3 4 5 6 7 8 9 10

12d. Circle your worst pain score the last 7 days
0 1 2 3 4 5 6 7 8 9 10

2. Do you have pain: ☐ constantly (90-100% of the time) ☐ frequently (75% of the time)
☐ intermittently (50% of the time) ☐ occasionally (25% or less of the time)

3. On a scale of 1-10 how do you rate your pain at its best? _____ At its worst? _____

4. Where do you have pain?
☐ Head ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Lower Back
☐ Shoulder R / L ☐ Arm R / L ☐ Elbow R / L ☐ Wrist R / L ☐ Hand R / L
☐ Leg R / L ☐ Knee R / L ☐ Ankle R / L ☐ Foot R / L Other: _____

5. Does your pain radiate to your arms? *(Please choose which apply)* ☐ Yes ☐ No
If yes, does it radiate to which arm? ☐ R ☐ L or ☐ both.

6. Does your pain radiate to your legs? *(Please choose which apply)* ☐ Yes ☐ No
If yes, does it radiate to which leg? ☐ R ☐ L or ☐ both.

7. Do you have any tingling? ☐ Yes ☐ No *(Please choose which apply)*
If yes, where do you have it in your: ☐ Arms ☐ Legs ☐ Hands or ☐ Feet

8. Do you have any numbness? ☐ Yes ☐ No *(Please choose which apply)*
If yes, where do you have it? ☐ Arms ☐ Legs ☐ Hands or ☐ Feet

9. Do you have any weakness? ☐ Yes ☐ No *(Please choose which apply)*
If yes, where do you have it ☐ Arms ☐ Legs ☐ Hands or ☐ Feet

10. Do you have any complaints of bowel or bladder problems? *(Please choose which apply)*
☐ Yes ☐ No

11. Has your pain improved? ☐ Yes ☐ No *(Please choose which apply)*
If yes, it ceased with which of the following?
☐ Rest ☐ Medication ☐ Heat ☐ Ice ☐ Elevation ☐ Bracing ☐ Compression
Other:_____

12. If you pain has not improved, what aggravates the pain? *(Please choose which apply)*
☐ Bending ☐ Prolonged standing ☐ Prolonged sitting ☐ Reaching
☐ Kneeling ☐ Prolonged walking ☐ Stooping ☐ Crawling ☐ Prolonged sitting

13. If you have both back and leg pain: My back is _____% of my pain. My leg is _____% of my pain.

13a. If you have both neck and arm pain: My neck is _____% of my pain. My arm is _____% of my pain.

14. My symptoms have been: ☐ improving ☐ unchanged ☐ worsening

15. What increases or decreases your pain? Place check in appropriate column

INCREASES YOUR PAIN		DECREASES YOUR PAIN
☐	Bending Forward	☐
☐	Bending Backwards	☐
☐	Sitting	☐
☐	Standing	☐
☐	Walking	☐
☐	Exercise	☐
☐	Coughing or Straining	☐
☐	Bowel Movements	☐
☐	Lying Down	☐
☐	Medications	☐
☐	Relaxation	☐
☐	Pushing shopping cart and leaning forward	☐

16. How many blocks can you walk before having to stop because of pain: ____ blocks

17. Functional limitations during the past month, what activities you avoided because of pain?

☐Going to work ☐ Performing household chores ☐ Doing yard-work or shopping
☐Socializing with friends ☐ Participating in recreation ☐ Having sexual relations
☐ Physically exercising ☐Driving ☐ Caring for self

18. Have you experienced any bowel or bladder changes? ☐ Yes ☐ No
If so what? ☐ Constipation ☐ Losing Urine ☐ Losing Bowels Other:_____

MEDICATIONS:

19. Please check the medications that you are currently on. Indicate the dosage and number of pills you are taking per day. Cross out medications that you have tried in the past, indicate the reason for stopping.

NARCOTICS	**ANTINFLAMMATORIES (NSAIDS)**	**ANTIDEPRESSANTS**
☐ Codeine	☐ Aleve (Naproxen)	☐ Celexa
☐ Darvocet (Propoxyphene)	☐ Celebrex	☐ Cymbalta
☐ Demerol (Meperidine)	☐ Feldene (Piroxicam)	☐ Elavil (Amitriptyline)
☐ Dilaudid (Hydromorphone)	☐ Ibuprofen (Motrin, Advil)	☐ Effexor (Venlafaxine)
☐ Fentanyl (Duragesic patch)	☐ Indomethacin (Indocin)	☐ Desyrel (Trazodone)
☐ Levorphanol	☐ Lodine (Etodolac)	☐ Lexapro
☐ Lortab	☐ Naprosyn (Naproxen)	☐ Norpramin (Desipramine)
☐ Methadone	☐ Relafen (Nabumetone)	☐ Pamelor (Nortriptyline)
☐ MS Contin	☐ Toradol (Ketorolac)	☐ Proxac (Fluoxetine)
☐ Oxycodone (Roxicodone)		☐ Paxil (Paroxetine)
☐ Oxycontin	**SLEEPING MEDS**	☐ Serzone (Nefazodone)
☐ Percocet	☐ Ambien (Zolpidem)	☐ Sinequan (Doxepin)
☐ Tylenol with codeine	☐ Lunesta	☐ Wellbutin (Bupropion)
☐ Vicodin (Hydrocodone)		☐ Zoloft (Sertraline)
☐ Norco	**BLOOD THINNERS**	
	☐ Aspirin	**OTHERS:**
☐ Ultram (Tramadol)	☐ Coumadin	☐ Lidoderm patches 5%
	☐ Plavix	☐ Depakote (Valproic acid)
MUSCLE RELAXANTS		☐ Dilantin (Phenytoin)
☐ Baclofen (Lioresal)	**ANTI-ANXIETY**	☐ Lamictal (Lamotrigine)
☐ Flexeril (Cyclobenzaprine)	☐ Ativan (Lorazepam)	☐ Lyrica
☐ Norflex (Orphenadrine)	☐ Buspar (Buspirone)	☐ Neurontin (Gabapentin)
☐ Robaxin (Methocarbamol)	☐ Halcion (Triazolam)	☐ Phenobarbital
☐ Soma (Carisoprodol)	☐ Klonopin (Clonazepam)	☐ Tegretol (Carbamezapine)
☐ Zanaflex (Tizanidine)	☐ Serax (Oxazepam)	☐ Topomax (Topiramate)
	☐ Valium (Diazepam)	
	☐ Xanax (Alprazolam)	

21a. Please list other medications:

21. Who prescribes your pain medications now? ☐ PCP Name:_____

☐ Pain management physician Name:_____ ☐ Emergency room

ALLERGIES:

22. Are you allergic to any medications? ☐ Penicillin ☐ Sulfa ☐ OTHER:_____

23. Are you allergic to: ☐ Latex ☐ X-ray ☐ Contrast dye ☐ Iodine

24. Have you ever had any problems with anesthesia/sedation? ☐ Yes ☐ No

Please describe _____

25. Is there any chance you might be pregnant? ☐ Yes ☐ No ☐ N/A

PAST MEDICAL HISTORY:

26. Have you had any previous problems with the current body parts injured? ☐ Yes ☐ No
If yes explain:_____

27. Automobile Accidents:
Have you had any prior motor vehicle accidents? ☐ Yes ☐ No
If yes explain:_____

28. Industrial Injuries:
Have you had any prior industrial related injuries? ☐ Yes ☐ No
If yes explain:_____

29. Have you ever had any of the following health problems?

☐ Diabetes Type I II	☐ Stroke (TIA)	☐ Seizure or Epilepsy	☐ HIV / AIDS
☐ High Blood Pressure	☐ Asthma	☐ Bleeding	☐ Hepatitis A B C
☐ Heart Attack	☐ Chronic Cough	☐ Cancer	☐ Syphilis
☐ Kidney disease	☐ Arthritis	☐ Other	

Other Medical Problems:

1.	5.
2.	6.
3.	7.
4.	8.

List all Surgeries:

1.	Date:
2.	Date:
3.	Date:
4.	Date:

FAMILY HISTORY:

28. I have a family history of: ☐ Back pain ☐ Migraine headaches ☐ Cancer
☐ Diabetes ☐ Hypertension ☐ Suicide ☐ Psychiatric Illness ☐ Other:_____

SOCIAL HISTORY:

29. Do you drink alcohol? ☐ Not at all ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Every day

Have you ever abused alcohol? ☐ Yes ☐ No

Have you ever been in Alcoholics Anonymous? ☐ Yes ☐ No

29a. Have you ever abused drugs? ☐ Yes ☐ No if yes, please name:_____

30. I am currently smoking ☐ Yes ☐ No _____ packs of cigarettes per day for _____ years.

30a. I quit smoking _____ years ago.
I used to smoke ____packs of cigarettes per day for ____years.

31. Do you exercise on a regular basis: ☐ Yes ☐ No if yes average ____ min/day x _____ times/week.

32. Are you: ☐ single ☐ married ☐ widowed ☐ separated ☐ divorced ☐ married?

Who do you live with? ☐ Alone ☐ with parents ☐ with friends ☐ with spouse/partner ☐ with children

33. What is the highest level of education you have completed?
☐ Some high school ☐ High school diploma / GED ☐ Some college ☐ College graduate
☐ Postgraduate program

EMPLOYMENT HISTORY AND CURRENT WORK STATUS:

1. Are you currently working? ☐ Yes ☐ No

If yes, are you still working for the same company? ☐ Yes ☐ No

What is your occupation?_____

What is your employer's name? _____

When did you start working for this company?_____

If no, when was the last day you worked? _____

2. Are you working: ☐ full time ☐ part time ☐ Retired
Are you: ☐ temporarily disabled ☐ permanently disabled ☐ permanent and stationary?

3. If you have settled your claim, do you have future medical care? ☐ Yes ☐ No

4. Are you working under light duty and with restrictions? ☐ Yes ☐ No
If yes, what are you restricted from?
☐ Bending ☐ Stooping ☐ Squatting ☐ Twisting ☐ Turning ☐ Pushing ☐ Pulling
☐ Prolonged standing, walking, sitting ☐ Lifting more than_____pounds

5. If you are currently not working are you on disability? ☐ Yes ☐ No
If yes, what doctor placed you on disability and for how long?_____

6. Are you receiving disability benefits? ☐ Yes ☐ No
If yes, it is from the ☐ EDD (State Disability) ☐ Workers Compensation carrier

7. Has your employment status been affected by your present pain condition? ☐ Yes ☐ No

REVIEW OF SYSTEMS: (CIRCLE ALL THAT APPLY)

General:	Fever Unplanned weight loss Night sweats
Eyes:	Glaucoma Double vision Blurred vision Blind spots
Nose/Ears:	Sinusitis Bleeding Congestion Hearing Loss
Throat:	Sore throat Difficulty swallowing hoarseness snoring
Heart:	Chest pain Previous heart attack murmur dizzy spells congestive heart failure
Lungs:	Wheezing Shortness of breath Cough Tuberculosis
GI:	Abdominal pain Heartburn Nausea Vomiting Diarrhea Constipation Incontinence Rectal Bleeding Ulcers
GU:	Sexual dysfunction Urinary retention Urinary incontinence
Musculoskeletal:	Joint pains Knee pain Shoulder pain Restricted movement
Skin:	Rash Lesions Change in hair or nails
Neurological:	Seizures Dizziness Weakness Drowsiness Trouble walking Problems controlling bowel/bladder
Psychiatric:	Difficulty falling or remaining asleep Excessive fatigue Feeling depressed Memory loss
Endocrine:	Heat / Cold intolerance Diabetes Thyroid disorder
Hematology:	Easy bruising Low platelet count Enlarged lymphnodes

In today's interview and examination will you need the assistance of an interpreter? ☐ Yes ☐ No
If you know what is the interpreter's name: _____

I hereby authorize the release of the reports of my evaluations and treatments to my physicians and to other relevant persons listed below:

Physicians/Providers Attorney/Case Manager/Other:	**Address:**	**Phone:** **Fax:**
Referring Doctor:		
Primary Care Physician:		
Case Manager:		
Adjuster		
Lawyer		

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors that I may have made in the completion of this form.

Patient's Signature_____Date: _____

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Gary Martinovsky, M.D.
Interventional Pain Medicine

All patients must fill in all sections in bold, if applicable.

Patient Name: _____DOB:_____
First M.I. Last
Martial Status: Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( )
Spouse's Name: _____
Name of person legally responsible if other than patient: _____
Patient Address: _____City: _____State:_____Zip:_____
Home Phone: _____Mobile Phone: _____
Work Phone: _____
Patient's Social Security Number: _____
Driver License#: _____
Patient's Employer: _____
Occupation/Job Title: _____
Employer's Address: _____
Employer's Phone Number: _____

Primary Insurance: _____Subcriber:_____
Subscriber ID#: _____ Group:
_____
Insurance Address: _____
Phone #: _____

Referred to this office by: _____
Address: _____
Phone:_____

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health place to **Gary Martinovsky, M.D., Integrated Pain Care, Inc.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure payment.

Patient Signature:_____Date: _____