LTA PAIN PHYSICIANS

Name:_____ Consultation Requested by:_____
Date: _____Age: _____ Primary Care Physician:_____

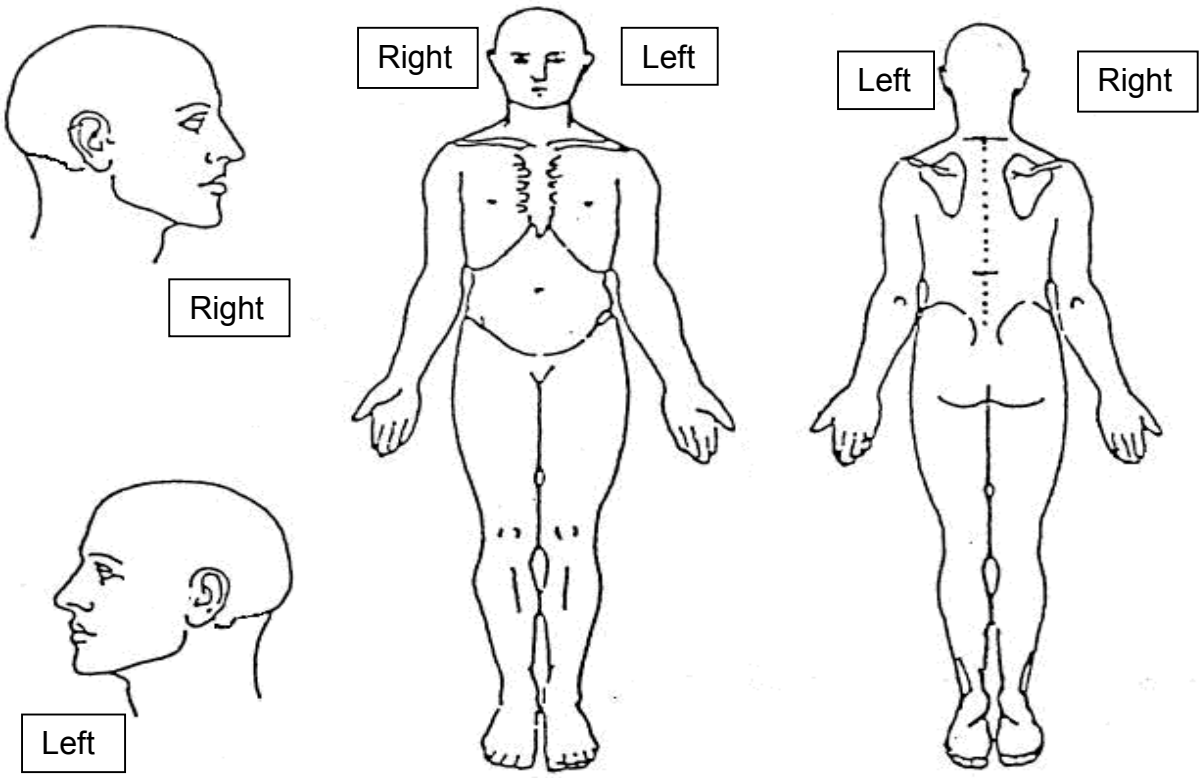
1. Use the following Numeric Rating Scale to indicate how severe your pain seems. Circle the appropriate number.

Your pain at its worst:
No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Your pain as it usually is:
No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Your pain currently:
No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

2. Please shade in the area of your pain.



3. What is your chief pain complaint? (We realize you may have multiple regions of pain but would like to understand where your chief pain is located--i.e. low back pain, neck pain, leg pain etc.).

_____

Under what circumstances did pain begin? (Check one)

[ ] Accident at work
[ ] Accident at home
[ ] At work, but not an accident
[ ] Pain just began, no reason
[ ] Other (describe)_____
[ ] Motor vehicle accident
[ ] Following surgery
[ ] Following illness

When did this pain begin? _____

4. Which terms best describe your pain?

	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

5. Which statement best describes your pain?
   [ ] Always present, always the same intensity.
   [ ] Always present, intensity varies.
   [ ] Usually present, but I have short periods without pain.
   [ ] Sometimes present, but I am pain-free for the majority of the day.
   [ ] Occasionally present, I have pain once to several times per day, lasting a few minutes to an hour.
   [ ] Occasionally present for brief periods, a few seconds to a few minutes.
   [ ] Rarely present, have pain every few days or weeks.

6. What makes your pain feel worse?
   [ ] Coughing, Sneezing
   [ ] Sitting
   [ ] Standing
   [ ] Lying Down
   [ ] Walking
   [ ] Physical Activity
   [ ] Sexual Activity
   [ ] Other (describe)_____

7. What makes your pain feel better?
   [ ] Relaxation
   [ ] Sitting
   [ ] Standing
   [ ] Lying Down
   [ ] Walking
   [ ] Nothing makes it feel better
   [ ] Medicines
   [ ] Heat
   [ ] Sexual Activity
   [ ] Alcoholic Drinks
   [ ] Other (describe)_____

8. Does pain interrupt your sleep? (Check one)
   [ ] Not at all
   [ ] Once per night
   [ ] Twice per night
   [ ] Three times per night
   [ ] More than three times per night

9. Have you had nerve blocks or other injections for pain relief? [ ] Yes [ ] No
   If yes, name of doctor:_____
   Did they relieve the pain? [ ] Yes [ ] No
   If yes, how long did relief last?
   [ ] Less than one day
   [ ] A few days
   [ ] A few weeks
   [ ] More than one month

10. Have you been treated with physical therapy? [ ] Yes [ ] No
    If yes, how long ago?_____ Was this beneficial? [ ] Yes [ ] No

11. Have you had any of the following for pain relief? If yes, did it relieve your pain?

Hypnosis	[ ] No	[ ] Yes	[ ] Relief
Biofeedback	[ ] No	[ ] Yes	[ ] Relief
Tens (Electrical Stimulation)	[ ] No	[ ] Yes	[ ] Relief
Acupuncture	[ ] No	[ ] Yes	[ ] Relief
Chiropractic Treatment	[ ] No	[ ] Yes	[ ] Relief
Heat Therapy	[ ] No	[ ] Yes	[ ] Relief
Bed Rest	[ ] No	[ ] Yes	[ ] Relief
Traction	[ ] No	[ ] Yes	[ ] Relief
Osteopathic Treatment	[ ] No	[ ] Yes	[ ] Relief
Psychotherapy	[ ] No	[ ] Yes	[ ] Relief
Other (describe)	[ ] No	[ ] Yes	[ ] Relief

_____

12. Rate your ability to cope with your pain. (Circle the appropriate number.)

    Unable to Cope 0 1 2 3 4 5 6 7 8 9 10 Cope Very Well

13. Do you feel that your pain situation is hopeless?

    Very Hopeless 0 1 2 3 4 5 6 7 8 9 10 Never Hopeless

14. Please rate your level of activity before and after your pain began:

    Before Pain Began: No Activity 0 1 2 3 4 5 6 7 8 9 10 Very Active

    After Pain Began: No Activity 0 1 2 3 4 5 6 7 8 9 10 Very Active

15. Have you ever had psychological or psychiatric treatment? [ ] Yes [ ] No

16. Have you ever been physically or sexually abused? [ ] Yes [ ] No

17. CURRENT MEDICATIONS:
    a. Medications **for pain** (please bring the bottles with you to your appointments):

Medication Name	Dosage	Times/Day	When Used Last

    b. Previous Medications used **for pain**:

Medication Name	Dosage	Times/Day	When Used Last

    c. Medications **for all other conditions**:

Medication Name	Dosage	Times/Day

_____
_____
_____
_____
_____

d. List all medical **allergies**:

_____
_____
_____
_____
_____
_____
_____

18. Are you considering taking opioid (narcotic) medications for your pain? ___Yes ___No

19. PAST MEDICAL HISTORY:

List medical problems such as diabetes, cancer, high blood pressure, heart disease etc. (other than pain)

_____
_____
_____
_____
_____
_____
_____

Have you had surgery for your pain?
[ ] No, I have not had surgery. [ ] Yes Number of operations: _____

Operation	Hospital	Date	Surgeon

20. Have you **had any other surgery for other** reasons (i.e. tonsillectomy, appendectomy etc.)?

Operation	Hospital	Date	Surgeon

21. SOCIAL HISTORY:

a. Are you: [ ] Married [ ] Never Married [ ] Divorced [ ] Widowed

b. Do you live: [ ] Alone [ ] With Spouse [ ] With Children (how many?_____)
[ ] With Relatives [ ] With Friend(s), Roommate(s)

c. Do you have any children? [ ] Yes [ ] No If yes, how many?_____

d. What is the highest grade in school you completed?_____

e. Do you drink alcohol? [ ] Yes [ ] No If yes, how much?_____
Have you ever cut down on drinking? [ ] Yes [ ] No
Or ever felt annoyed by criticisms about drinking? [ ] Yes [ ] No
Or had guilty feelings about drinking? [ ] Yes [ ] No
Or taken an "eye opener" in the morning? [ ] Yes [ ] No

f. Do you now smoke cigarettes (as of one month ago)? [ ] Yes [ ] No
Would you like to talk to the doctor about quitting? [ ] Yes [ ] No

g. Do you have any prior history of drug abuse? [ ] Yes [ ] No

24. FAMILY HISTORY:
Does your family have a history of these or other significant medical problems?
Relationship to you.

[ ] Diabetes _____
[ ] Hypertension _____
[ ] Heart Disease _____
[ ] Strokes _____
[ ] Cancer _____
[ ] Other (specify) _____

25. WORK HISTORY:
a. What is your occupation? _____
b. Specifically, what are your duties? _____
c. Do you work: [ ] Full Time [ ] Part Time [ ] Don't Work [ ] Self-Employed
d. If unemployed, last date worked_____
e. Did you / do you find your job satisfying? [ ] Yes [ ] No
f. Did you stop working because of your pain? [ ] Yes [ ] No
g. Have you received financial compensation related to your pain? [ ] Yes [ ] No
If yes, is the case closed? [ ] Yes [ ] No
h. Are you receiving continued financial support related to your pain? [ ] Yes [ ] No

26. Are you pursuing a lawsuit because of your pain? [ ] Yes [ ] No

Continue on next page

27. REVIEW OF SYSTEMS: Check if you have a history of the following:

GENERAL:
[ ] Fatigue
[ ] Fever
[ ] Chills
[ ] Change in weight
[ ] Trouble sleeping
[ ] Depression
[ ] Nervousness
[ ] Panic Attacks

ALLERGIES:
[ ] Food_____
[ ] Pollens
[ ] Other_____

HEAD AND NECK:
[ ] Headache or neck pain
[ ] Visual Problems
[ ] Nose Problems
[ ] Mouth Sores
[ ] Hearing Problems
[ ] Sinus Problems

HEART:
[ ] Irregular Beat
[ ] High Blood Pressure
[ ] Heart Murmur
[ ] Chest Pain
[ ] Heart Attack(s)
[ ] Swelling of Ankles
[ ] Leg Cramps
[ ] Blood Clots/Inflamed Veins (phlebitis)

BLOOD:
[ ] Anemia or Low Blood Cell Count
[ ] Enlarged Lymph Node(s)
[ ] Bleeding Disorder

NEUROLOGIC:
[ ] Loss of Consciousness
[ ] Difficulty Thinking/Concentrating
[ ] Difficulty with Memory
[ ] Incoordination
[ ] Weakness or Paralysis
[ ] Muscle Wasting
[ ] Problem Walking
[ ] Vertigo or Dizziness
[ ] Numbness or Tingling

ENDOCRINE:
[ ] Diabetes
[ ] Thyroid Disease
[ ] Radiation Exposure
[ ] Goiter
[ ] Increased Perspiration
[ ] Excessive Thirst
[ ] Heat or Cold Intolerance

SKIN AND HAIR:
[ ] Skin Ulcers or Sores
[ ] Growths or Lumps
[ ] Rash
[ ] Loss of Hair
[ ] Bruising
[ ] Hands turning blue or white

UROLOGICAL:
[ ] Leakage of Urine
[ ] Frequent Infections
[ ] Frequent Urination
[ ] Nighttime Urination
[ ] Pain during Urination
[ ] Discharge/Genital Discomfort
[ ] Loss of Control
[ ] Trouble Starting
[ ] Blood in Urine
[ ] Dark Urine
[ ] Kidney Stones

MUSCULOSKELETAL:
[ ] Muscle Aches
[ ] Back Pain
[ ] Joint Pain
[ ] Gout

GASTROINTESTINAL:
[ ] Problems Swallowing
[ ] Appetite Change
[ ] Abdominal Pain
[ ] Nausea or Vomiting
[ ] Vomiting Blood
[ ] Black Stool or Blood in Stool
[ ] Jaundice
[ ] Diarrhea
[ ] Constipation
[ ] Heart Burn
[ ] Ulcers
[ ] Excessive Gas or Bloating
[ ] Food Intolerance _____
[ ] Colitis

INFECTIOUS:
[ ] Tuberculosis
[ ] Travelers' Diarrhea
[ ] Hepatitis
[ ] Parasites
[ ] Measles
[ ] Mumps
[ ] Chicken Pox
[ ] Malaria
[ ] Typhoid Fever
[ ] Infectious Mononucleosis
[ ] Other _____

LUNGS:
[ ] Shortness of Breath
[ ] Pneumonia
[ ] Cough
[ ] Pleurisy
[ ] Coughing up Blood
[ ] Wheezing or Asthma