Chronic Pain Management

New Patient History and Intake Form

CBSI COLORADO BRAIN & SPINE INSTITUTE

Name: ____ **Age:** ________ **Date of Birth:** _______________ ☐**Right-handed** /☐**Left-handed**☐**Male**/☐**Female**	**Referring Provider:** ___________________________ **Primary Care Provider:** ________________________ **Other Provider(s) you would like CBSIto notify about your visit:** ______________________________

In general, my OVERALL health is:(Mark ONLY ONE)☐Excellent☐Very Good☐Good☐Fair ☐Poor

My CHIEF PAIN COMPLAINT is:(Mark only ONE)			**My ADDITIONALpain complaint(s) is (are):**(Mark ALL that apply)		
☐ headache	☐ neck pain	☐ left arm pain	☐ headache	☐ neck pain	☐ left arm pain
☐ facial pain	☐ mid-back pain	☐ right arm pain	☐ facial pain	☐ mid-back pain	☐ right arm pain
☐ chest wall pain	☐ low-back pain	☐ left leg pain	☐ chest wall pain	☐ low-back pain	☐ left leg pain
☐ abdominal pain	☐ buttock pain	☐ right leg pain	☐ abdominal pain	☐ buttock pain	☐ right leg pain
☐ groin pain	☐ tailbone pain	☐ other: ___________	☐ groin pain	☐ tailbone pain	☐ other: ____________

My pain first began:(Mark ONE in each row)		**The cause of my pain is:**(Mark only ONE)		**The frequency of my pain is:**(Mark ONE in each column)	
☐ Gradually	☐ Abruptly	☐ surgery	☐ sports-related	☐ constant	☐ Getting better
☐ 0-3 months ago	☐ 1-5 years ago	☐ a fall	☐ a car accident	☐ fluctuating but always present	☐ Getting worse
☐ 3-6 months ago	☐ 5-10 years ago	☐ normal aging	☐ unknown	☐ fluctuating but usually present	☐ About the same
☐ 6-12 months ago	☐ 10+ years ago	☐ work-related	☐ other: _______	☐ fluctuating but rarely present	

My pain is worse in the: ☐mornings ☐during the day ☐evenings ☐ in the middle of the night ☐ other:__________________

Describe your pain severity: (0 = No pain, 10 = Unbearable pain)

Now:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Worst:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Least:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Average:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Indicate where your pain is located:

1. Use the following letters to describe your pain.

Ache = A
Burning = B
Cramping = C
Dull = D
Numbness = N
Pins/Needles = P
Stabbing = S
Throbbing = T

2. Draw arrows where the pain radiates.

Please indicate if the following INCREASE, DECREASE or cause NO CHANGE in your pain: (Place a check mark for all that apply)

	Increase	Decrease	No Change
Heat			
Cold			
Weather Changes			
Sitting			
Standing			
Walking			
Exercise			
Bending forward			
Leaning back			
Twisting at waist (R/L)			
Looking up			
Looking down			
Rotating neck (R/L)			
Lying down			
Lying on side (R/L)			
Massage therapy			
Physical therapy			
Bowel movement			
Sneezing/coughing			
Stress			
Medications			
Other:			

Describe your functional and other abilities: (0 = Not able, 10 = Very able)

My ability to cope with my pain:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

My ability to perform my activities of daily living, such as hygiene, household chores, transportation, etc.:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

My ability to function and interact well with family and friends:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

My ability to work in my usual occupation:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

My ability to sleep well:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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In the past three (3) months have you developed any of the following associated symptoms or concerns? (Mark ALL that apply)

☐Balance problems	☐Fever	☐Falls/Near falls – When? ___________________________	☐Need for a cane
☐Difficulty walking	☐Chills	☐Numbness/Tingling – Where? ______________________	☐Need for a walker
☐Bladder incontinence	☐Nausea	☐Weakness – Where? ______________________________	☐Need for other assistive devices: ____________________
☐ Bowel incontinence	☐Vomiting	☐ Problems with fine motor control (buttoning your shirt, using a pencil) - ____________________________________	
☐Mood changes	☐Diarrhea		☐Other: ___________________

Mark all of the following TESTS you have had to evaluate your current pain complaint(s): (Mark ALL that apply)

Test	Date(s)	Body Part/Area	Location/Facility
☐X-Ray			
☐CT Scan			
☐MRI			
☐EMG/NCV			
☐Vascular studies			
☐Discogram			
☐Other: __________			
☐**I have not had any tests for my current pain complaint(s).**			

Mark all of the following TREATMENTS FOR YOUR PAIN that you have had PRIOR to this visit: (Mark ALL that apply)

Treatment	Body Part/Area	Date(s)	Worse	No Relief	Mild Relief (up to 30%)	Moderate Relief (30-70%)	Excellent Relief (> 70%)
☐Chiropractic							
☐Acupuncture							
☐Massage Therapy							
☐Physical Therapy							
☐Aqua/Pool Therapy							
☐Weight Loss Program							
☐Neck/Back Brace							
☐TENS Unit							
☐Trigger Point Injection							
☐Epidural Steroid Injection							
☐Facet Injection							
☐Medial Branch Blocks							
☐Radiofrequency Ablation							
☐Sacroiliac Joint Injection							
☐Other Joint Injection							
☐Muscle Injection							
☐Peripheral Nerve Block							
☐Sympathetic Nerve Block							
☐ Spinal Cord Stimulator							
☐Intrathecal Pump							
☐Ketamine Infusion							
☐Vertebroplasty							
☐Kyphoplasty							
☐Joint Replacement							
☐Spinal Surgery							
Surgery #1							
Surgery #2							
Surgery #3+							
☐Psychological Therapy – Therapist:							
☐Other Treatment:							
☐**I have not had any treatments for my current pain complaint(s).**							

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Please list ALL medications that you CURRENTLY take for your PAIN. Include ALLprescription and over-the-counter medications.							
Medication Name	Dose	Frequency (How often?)	Prescribing Provider	No Relief	Mild Relief (up to 30%)	Moderate Relief (30-70%)	Excellent Relief (> 70%)

☐I am not taking any medications for my current pain complaint(s).

If you are currently taking pain medications, will the prescribing provider continue to prescribe these medications?☐Yes ☐No

If 'No', will Dr. Bernardini/CBSI be taking over these medications?☐ Yes☐No☐Unsure

Pain Medication History – Please mark all pain medications you have TRIED IN THE PAST.

Opioids

☐Fentanyl (Actiq, Fentora, Subsys, Duragesic)
☐Morphine (Avinza, Kadian, MS Contin)
☐Oxycodone (Oxycontin, Percocet)
☐Buprenorphine (Suboxone, Subutex, Butrans)
☐Tramadol (Ryzolt, Ryzolt ER, Ultram, Ultram ER)
☐Propoxyphene (Darvocet, Darvon)
☐Oxymorphone (Opana, Opana ER)
☐Hydromorphone (Dilaudid, Exalgo)
☐Hydrocodone (Vicodin, Norco, Lortab)
☐Tapentadol (Nucynta, Nucynta ER)
☐Demerol
☐Methadone
☐Codeine
☐Other: ______________

Anti-inflammatories & Tylenol (acetaminophen)

☐Aspirin (Bayer, BC Powder)
☐Acetaminophen (Tylenol)
☐Ibuprofen (Advil, Motrin)
☐Naproxen (Aleve, Naprosyn)
☐Celecoxib (Celebrex)
☐Oxaprozin (Daypro)
☐Indomethacin (Indocin)
☐Diclofenac (Arthrotec, Voltaren, Flector)
☐Etodolac (Lodine)
☐Meloxican (Mobic)
☐Nabumetone (Relafen)
☐Piroxicam (Feldene)
☐Ketoprofen
☐Ketorolac (Toradol)
☐Other: _______________

Muscle Relaxants

☐Baclofen (Lioresal)
☐Cyclobenzaprine (Flexeril, Amrix)
☐Methocarbamol (Robaxin)
☐Metaxalone (Skelaxin)
☐Tizanidine (Zanaflex)
☐Carisoprodol (Soma)
☐Valium
☐Other: ______________

Sleep Aids

☐Zolpidem (Ambien, Ambien CR)
☐Eszopiclone (Lunesta)
☐Temazepam (Restoril)
☐Zaleplon (Sonata)
☐Ramelteon (Rozerem)
☐Sodium Oxybate (Xyrem)
☐Melatonin
☐Other: ________________

Antidepressants

☐Duloxetine (Cymbalta)
☐Venlafaxine (Effexor)
☐Amytriptyline (Elavil)
☐Nortriptyline (Pamelor)
☐Escitalopram (Lexapro)
☐Paroxetine (Paxil)
☐Desvenlafaxine (Pristiq)
☐Fluoxetine (Prozac)
☐Mirtazapine (Remeron)
☐Nefazodone (Serzone)
☐Imipramine (Tofranil)
☐ Trazodone (Desyrel)
☐Bupropion (Wellbutrin)
☐Sertraline (Zoloft)
☐Other: ___________________

Anti-epileptics/Anti-convulsants & Neuropathic Agents

☐Gabapentin (Neurontin)
☐Pregabalin (Lyrica)
☐Topiramate (Topamax)
☐Tiagabine (Gabatril)
☐Carbamazipine (Tegretol)
☐Levetiracetam (Keppra)
☐Lamotragine (Lamictal)
☐Valproic Acid (Depakote, Depakene)
☐Phenytoin (Dilantin)
☐Zonisamide (Zonegran)
☐Oxcarbazepine (Trileptal)
☐Other: _________________

Other Medications

☐Imitrex
☐Maxalt
☐Zomig
☐Frova
☐Relpax
☐Amerge
☐Ergotamine
☐Midrin
☐Fioricet/Fiorinal
☐Lithium
☐Mexilitine
☐Lidoderm Patches
☐Topical compounds
☐Phenergan
☐Hydroxyzine (Vistaril)
☐ Botox (botulinum toxin) injections
☐Beta-Blockers (propranolol, metoprolol, atenolol, etc.)
☐Calcium Channel Blockers (verapamil, etc.)
☐Steroids (cortisone, Medrol dose pack)
☐Other: ____

Current Pain Medication Effectiveness

Overall, do your pain medications provide PAIN RELIEF? ☐Yes☐No☐I do not take pain medication

If 'Yes', how much pain relief do you receive?☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

Overall, do your pain medications IMRPOVE YOUR FUNCTION? ☐Yes☐No☐I do not take pain medication

If 'Yes', how much improvement do you receive?☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

Overall, do your pain medications IMPROVE YOUR QUALITY OF LIFE? ☐Yes☐No☐I do not take pain medication

If 'Yes', how much improvement do you receive?☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

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Please indicate any SIDE EFFECTS caused by your pain medication(Mark ALL that apply) ☐I do not take pain medication				
☐Nausea	☐Rash	☐Confusion	☐Acid Reflux	☐Memory loss
☐Vomiting	☐Itching	☐Dizziness	☐Constipation	☐Other: _____________
☐Diarrhea	☐Sedation	☐Upset Stomach	☐Urinary retention	☐No Side Effects

Please indicate which, if any, of the following BLOOD THINNING medications you are taking:(Mark ALL that apply)				
☐Anti-inflammatory	☐Pletal	☐ReoPro	☐Eliquis	☐Fish oil
☐Lovenox	☐Aggrenox	☐Pradaxa	☐Garlic	☐Coumadin (Warfarin)
☐Persantine	☐Effient	☐Arixtra	☐Ginseng	☐Aspirin (☐81 mg ☐ 325 mg)
☐Plavix	☐Ticlid	☐Xarelto	☐Gingko	☐Other: __________________

Have you previously been under the care of a PAIN MANAGEMENT SPECIALIST? ☐Yes☐No
If 'Yes', who was your treating physician? ___________________________________ **Dates of treatment:** _____________________
Which treatments were tried? ____
Why are you no longer under the care of that physician? ____

We are dedicated to helping you reduce your pain and improve your function. What are your TREATMENT GOALS?				
☐Enjoyment of life	☐Return to work	☐Housework	☐Bike riding	☐Driving
☐Improved activity	☐Walking	☐Golfing	☐Bowling	☐Skiing/Snowboarding
☐Improved mood	☐Running/Jogging	☐Fishing	☐Traveling	☐Playing with children/grand children
☐Improved sleep	☐Weight lifting	☐Gardening	☐Shopping	☐Other: ___________________________

Lifestyle, Social and Psychiatric History

Marital Status: ☐Single☐Married☐Separated☐Divorced ☐Widowed

Are you capable of becoming pregnant? ☐N/A (males)☐Yes☐No; **If 'Yes', are you currently pregnant?** ☐Yes☐No

Residential Status: (who you live with)☐Alone☐Friend/Roommate ☐Spouse☐Spouse & Children ☐Children ☐Parents

What is your current work status? ☐Employed (full-time)☐Employed(part-time)☐Unemployed☐Retired ☐Disabled
If you are unemployed, employed part-time, or have work restrictions, is this due to your current pain condition? ☐Yes☐No
What are your current work restrictions, if any? ('N/A' if not applicable) ____

Are you currently involved in litigation related to this pain? ☐Yes☐No (Attorney's name: _______________________________)

Tobacco Use: ☐Yes, currently ☐Yes, in the past ☐No, never

Alcohol Use: ☐Yes, socially☐Yes, daily limited use ☐Yes, current alcoholic☐No, but history of alcoholism ☐No, never

Have you had problems with prescription medications (misuse, abuse, addiction)? ☐Yes, currently☐Yes, in the past☐No
If 'Yes', which prescription medications? ____

Have you ever used any illegal street drugs (including marijuana)? ☐Yes, currently☐Yes, in the past☐No/Never
If 'Yes', which illegal street drugs? ____

Have you ever been treated for addiction or alcoholism? ☐Yes, currently☐Yes, in the past☐No/Never
If 'Yes', where? _____________________________________ **Do you regularly attend AA/NA or similar meetings?** ☐Yes☐No

Do you suffer from any of the following psychiatric conditions?		
☐Depression	☐Schizophrenia	☐Attention Deficit/Hyperactivity Disorder (ADD/ADHD)
☐Anxiety	☐Substance abuse/Addiction	☐Obsessive-Compulsive Disorder (OCD)
☐Bipolar Disorder	☐Personality Disorder	☐Other: ___________________________________

Do you currently see a psychiatrist? ☐Yes☐No; **If 'Yes', who are you seeing?** _____________________________________
Have you had any recent thoughts of hurting yourself or others? ☐Yes☐No

Anesthesia and Pain Procedure History

Have you ever had anesthesia? ☐Yes☐No
If 'Yes', have you ever had any problems or adverse reaction to anesthesia? ☐Yes☐No
If 'Yes', which type of anesthesia? __________________________ **What was the reaction?** ______________________________

Have you ever had any problems or adverse reaction to the iodine contrast used during a pain procedure? ☐Yes☐No
If 'Yes', what was the reaction? ____