

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Patient Visual Chart**

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Activity Level:

Increased     Decreased     Unchanged

New and/or corrected information (address, phone number, insurance, etc.)

Yes     No

If yes, please write new information here:

Primary Care Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Reason for today's visit:

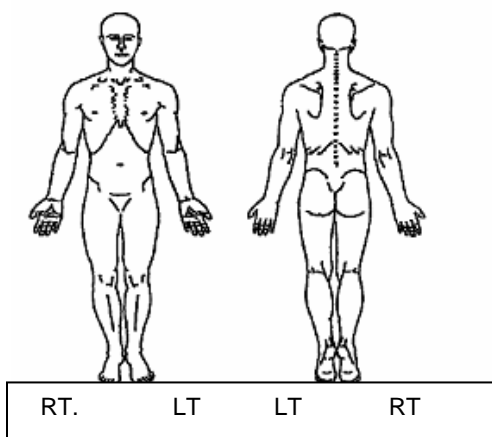
- New Patient Consultation     Review MRI / CT / X-Ray / Reports, Etc.  
 Medication Recheck     Post procedure recheck  
 Other

Recent changes in medication?     Yes     No

Any changes in health?     Yes     No

If yes, please list:

**Pain History – Please mark the location(s) of your pain on the figure below and circle all that apply.**



Quality: burning, numbness, dull aching, pins, needles, stabbing, throbbing

Pain level today:    0 1 2 3 4 5 6 7 8 9 10

Pain level with medication:    /10    Pain level with medication:    /10

Duration of pain:

- Constant     Most of the time  
 Comes and goes     Once in a while  
 Hardly ever

Comments:

**Below To Be Filled Out By Provider**

BP: \_\_\_\_\_ | PULSE: \_\_\_\_\_

Physical Exam

Refer To: \_\_\_\_\_

Obtain Imaging: \_\_\_\_\_

Schedule For Procedure(s):

- Cervical     ESI     Stellate Ganglion Block  
 Thoracic     SNRBA     Lumbar Sympathetic Block  
 Lumbar     Facet Injection     Discogram  
 SI Joint Injection     Other  
 Rhizotomy

With:     SCS Trial     SCS Implant     Single Lead     Dual Lead  
 BS     ANS     Medtronic     Stryker

Comments:

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Pain Questionnaire**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

1. Who referred you to Lewis Pain?

2. What problem are you here for?

3. Date of first onset (first episode):

4. Explain how the pain started:

5. Have you had any previous episodes?  YES  NO If "yes," when?

6. Have you had any prior surgery for this or a similar problem?  YES  NO

7. If "yes," list procedures and dates:

8. Over the last 1-2 weeks, is your pain getting:  Better  Worse  About the same

9. Location of greatest area of pain: Do you have radiation of pain?  YES  NO

10. How would you break down the components of your pain? (Totaling 100%)

Back: \_\_\_\_\_% Right Arm: \_\_\_\_\_% Right Leg: \_\_\_\_\_%  
 Neck: \_\_\_\_\_% Left Arm: \_\_\_\_\_% Left Leg: \_\_\_\_\_%  
 Other Pain: \_\_\_\_\_%

11. Frequency of your pain (Percent of the time):

Constant (80-100%)  Nearly Constant (50-80%)  
 Intermittent (25-50%)  Occasionally (less than 25%)

12. During the past month, is your pain worse in the:

Morning  Afternoon  
 Evening  Night  
 No specific time

13. Does the pain wake you up at night:  YES  NO

14. How many hours do you spend each day lying down because of pain?

15. How many times during the day do you lie down because of pain?

16. How do the following affect your pain?

	WORSE	NO CHANGE	BETTER
Lying Down			
Standing			
Sitting			
Movement (i.e. Walking)			
Exercises			
Going to work			
Medication			
Relaxation			
Thinking about other things			
Coughing and sneezing			
Urination			
Bowel Movement			

Name:

Date:

**Pain Questionnaire**

17. How much has your pain interfered with the following: (Check one for each.)

	ALL the time	MOST of the time	SOMETIMES	NEVER
Appetite				
Sleep				
Marriage/Family Life				
Social Activities/Friendships				
Sexual Activity				
Working at your job (if applicable)				
Housework/Chores				
Hobbies/Recreation				

18. Do you have numbness or tingling?  YES  NO If "yes," where?

19. Are you able to control urination?  YES  NO

20. Are you able to control bowel movements?  YES  NO

21. Does the affected extremity feel weak?  YES  NO

22. Please indicate previous therapy (you have tried) and the results:

	Worse (-1)	Some Help (1)	Moderate Help (2)	Profound Help (3)
Bed rest				
Anti-inflammatory (example: Aspirin, Nuprin, etc.)				
Muscle relaxants				
Narcotics (example: Tylenol #3, Vicodin, Darvocet, etc.)				
Heat				
Ice				
Physical therapy				
TENS (neurostimulator)				
Daily exercise				
Pain clinic				
Biofeedback				
Psychological treatment				
Chiropractic treatment				
Acupuncture or Acupressure				
Injections				
Massage				
Other				

23. Have you had regular x-rays?  YES  NO If "yes," when and where?

24. Have you had a CT scan?  YES  NO If "yes," when and where?

25. Have you had an MRI scan?  YES  NO If "yes," when and where?

26. What other tests have you had regarding this problem?

27. Are you:  Married  Single  Divorced  Widowed

28. Spouse's Name: \_\_\_\_\_ Years married: \_\_\_\_\_



Name:

Date:

**Patient Questionnaire**

38. Review of Systems: Please draw a circle around any symptom(s) or condition(s) in this section which you have previously had, or currently suffer from. If your symptom(s) or condition(s) is not in the list, please add it in the "other" category.

**General:** Anemia Blood Clots Osteoporosis Neck Pain Sciatica  
 Phlebitis HIV or AIDS Lower Back Pain Arthritis Bleeding Disorder  
 Psoriasis or other skin problem

**Eyes, Ears, Nose, and Throat:** Loss or change of vision Eye pain or redness Excessive watering of ears, eyes, nose, throat Excessive Sneezing Ear infection or drainage  
 Double vision Hoarseness Loss of hearing Buzzing or noises in ear(s) Other: \_\_\_\_\_

**Respiratory:** Wheezing Pneumonia Bloody Sputum Large quantity of sputum Excessive coughing  
 Tuberculosis Emphysema Asthma Night sweats Pain with breathing  
 Shortness of breath at rest or with little exercise Other: \_\_\_\_\_

**Cardiovascular:** Chest pain Varicose veins Fibrillation Heart murmur Heart attack  
 High blood pressure Abnormal or fast heartbeat Abnormally low blood pressure Calf cramps when walking Rheumatic fever  
 Excessive sensitivity of fingers/toes too cold Frequent and marked swelling in ankles and feet Other: \_\_\_\_\_

**Gastrointestinal:** Diabetes Frequent nausea Bloody vomit Digestion difficulty Hepatitis  
 Jaundice Ulcers Frequent belching Hiatal hernia Pancreatitis  
 Anemia Frequent loose bowel movements Lack or loss of appetite Hemorrhoids or recurring diarrhea piles Gallbladder trouble  
 Blood in stool Frequent stomach or abdominal pain Persistent anal itch Other: \_\_\_\_\_

**Genitourinary:** Painful urination Blood in urine Flank pain Excessive urination Narrowing of urinary stream  
 Chronic urgency of urination Difficulty starting/passing urine Increased frequency of urination Urinary incontinence/dribbling Other: \_\_\_\_\_

**Male Patients:** Penile pain Infection or sores Prostatitis Scrotal swelling Varicocele  
 Sterility Abnormality of testicles Difficulty in sexual functioning Stricture Other: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Pain Questionnaire**

**Female Patients:**

Breast discharge	Breast pain	Painful menses	Breast infection	Vaginal pain
Breast swelling or lumps	Nipple changes or irritation	Vaginal discharge or itch	Vaginal infection	Uterine fibroids/tumors
Tubal infections	Infertility or difficulty becoming pregnant	Marked changes in body hair distribution	Abnormality of menstrual flow	Difficulty in sexual functioning
Other: _____		Date of last menstrual period: _____	Number of pregnancies: _____	Number of live births: _____

Is it possible that you are pregnant?     YES     NO

\*If you could be pregnant, please notify the doctor.

**Neurological:**

Strokes	Dizziness	Fainting spells	Blackouts	Paralysis of limbs
Shaking or twitching spells	Severe lapses of memory	Frequent or constant numbness/tingling of body parts	Unusual head or neck tension	Severe or frequent headaches
Seizures, fits, or convulsions		Other: _____		

**Emotional or Psychological:**

Depression	Insomnia	Excessive worry	Emotional illness	Severe tension
Recurrent fear	Nervous exhaustion	Hysterical attacks	Frequent crying	Frequent nightmares
Nervous breakdown	Constant unhappiness	Feelings of worthlessness	Recurrent feelings of loneliness / hopelessness	Other: _____

39. Family History: Please complete the following, and note all medical conditions for each person. (Refer to "List of Conditions" under "Past History" on page 3.) Also add any orthopedic conditions or symptoms that you now have, and any family member currently has or has had.

	Deceased (D) or Living (L)	Current Age or Age at Death	Medical Conditions, including cause of death if deceased
Father			
Mother			
Brother(s)			
Sister(s)			
Children			