

Pain Questionnaire & Medical History

Dayton Pain Center, LLC / Dayton

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ /19\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ /2012

Referring Physician: \_\_\_\_\_ Primary care Physician: \_\_\_\_\_

Circle and use check marks when appropriate. Down loading and proper filling it prior to coming to the office visit will save you waiting time. You will not be seen with out completed forms.

I: **Chief Complaint(s):** Describe in your words where it is? what pain is like, How it feels? **When and how** did your problem first started (accident, injury etc?) Describe each area of pain separately. If BWC, describe the first injury in detail & job title and duty.

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

**HPI: Severity of pain level Location:** ( In a scale of 0 - 10 per body part. 0 being no pain, 10 being worst pain in your life)

Head \_\_\_\_\_ Face: \_\_\_\_\_ Neck: \_\_\_\_\_ Thorax: \_\_\_\_\_ Lumbar: \_\_\_\_\_ Lumbo-sacral: \_\_\_\_\_

Extremities: Upper: R \_\_\_\_\_ L \_\_\_\_\_ Lower: R \_\_\_\_\_ L \_\_\_\_\_ Chest: \_\_\_\_\_ Abdomen: \_\_\_\_\_ Other \_\_\_\_\_

Joints: Shoulder: \_\_\_\_\_ Elbow: \_\_\_\_\_ wrist: \_\_\_\_\_ Hip: \_\_\_\_\_ Knee: \_\_\_\_\_ Ankle: \_\_\_\_\_ Other \_\_\_\_\_

4. Does your pain radiate: Yes to \_\_\_\_\_ No \_\_\_\_\_
5. How long? Is it constant? Does it come and go? \_\_\_\_\_
6. How many hours you sleep? \_\_\_\_\_ Do you toss & turn?: Yes / No Does Pain Wakes you Up?: Yes / No
7. Have you seen any other Pain Physician(s)/Chiropractic physician: Yes \_\_\_\_\_ No \_\_\_\_\_
8. What type of injections you have? Bywhom? \_\_\_\_\_
9. Pain level without medications (0-10): \_\_\_\_\_ Pain level with medications (0-10): \_\_\_\_\_
10. Using the pain scale of 0-10 Please rate what your **acceptable AVERAGE LEVEL** of pain would be? \_\_\_\_\_
11. **Sleep** disturbance (difficulty falling/staying asleep) Yes / No. If yes **duration:** \_\_\_\_\_
12. Were you told that you snore while you are sleeping? No / Yes If yes did you have any sleep studies? Yes / No
13. Do you have perception of non-painful stimuli as being painful (Allodynia) Touch of cloths/bed sheets cause pain Yes / No

**Character (quality) of pain: Nociceptive:** Dull ache, cramping, waxing, waning, sharp, tender. \_\_\_\_\_

**Neuropathic:** Hot/burning, stabbing, electric shock, fan causing pain, tingling/numbness, shooting, pins/needles, \_\_\_\_\_

Which Movement is more painful? Is it Bending **Backwards**? Yes / No Is it Bending **forwards**? Yes / No

Altered feeling (Tingling / Numb / Burning / Bugs crawling / Electric shock like in Upper / Lower / extremities. \_\_\_\_\_

Do you have **muscle Spasms**? Yes / No How often? Frequently / Rarely / During night / None

**Modifying Factors:**

Pain aggravated by prolonged sitting, standing walking, bending squatting, climbing, lifting, pulling, pushing, and carrying \_\_\_\_\_

Pain relieved by rest, lying down, hot shower, heating pad, medications, exercise, TENS, bio-feed back, physical therapy \_\_\_\_\_

**Functional Ability in relation to pain and comfort on a daily basis with out pain medications:**

How is your ability to manage your relationship with others: \_\_\_\_\_

What is your ability to do daily activities or job: \_\_\_\_\_



**Fast treatments for the presenting problem (When, where, who performed & their efficacy).**

Previous Treatments	Yes	No	Helpful	Not helpful
Physical Therapy Tried?				
TENS Unit Tried?				
Tried Weight loss?				
Pain Blocks Tried?				
Exercise program tried?				
Counselling/Biofeed/Prolo				

H/O NSAIDS (Naprosyn, Ibuprofen etc) usage & the reasons for their **failure** ( side effects, Erosive Gastritis, GERD, Bleeding, cannot tolerate Vioxx, Celebrex, None of them are effective. They are effective one time but not any more

**Are you taking any Anxiety & Depression Medications**(circle): Xanax / Ativan / Klonipen / effexor / lexapro / abilify / seroqu

**Medication History other than pain meds** for the last 5 years:

Which **pain** medication(s) has helped: \_\_\_\_\_

Which **pain** medication(s) has not helped: \_\_\_\_\_

Are you on any **Blood thinners**? Aspirin / Plavix / Coumadin / NSAIDs / Tyclid / Alternative Health Remedies \_\_\_\_\_

**Side effects** of current or recent medication: None / Constipation / Nausea / Dry mouth / Sweating \_\_\_\_\_

**Medication Allergies:** Cannot tolerate NSAIDS / Tylenol with Codine / Morphine / Oxycodone / Ultram

If you are allergic what happened describe each one in detail: \_\_\_\_\_

**Have you used?** (Circle) Neurontin, Topomax, Lyrica, Elavil, Trazadone, lidoderm, dilantin, tegretol, Flector patches

Did they help ? Yes / No \_\_\_\_\_

**Quality of family life, Activities of daily living & social life improved with medications** Yes / No

Functional with medication: Working, Not working but functional, Functional with some limitation, Not functional Yes / No

Are you in compliance with treatment provided by your former doctors: Yes / No

**III: Review of Systems:** (Symptoms related to each system and how long)

**Head aches**, Duration Does it last longer than 4hrs Y / N Is the Head ache Moderate to Severe Y / N

Do you stay in dark room (Photophobia) Y / N Is your Head ache aggravated by physical activity Y / N

Do you suffer from Head-ache 15 days in a month, lasting more than four hours a day for longer than 3 months Y / N

**Aura:** Present / Not Present / Associated with Nausea / Need to stay in dark room / Morning / Evening

**Anxiety & Depression & Duration** (State how these effected by pain) \_\_\_\_\_

Have you been seen by a **psychiatrist / Psychologist** No / Yes by Dr \_\_\_\_\_

Do you have any suicide thoughts: Yes / No

Eyes: **Normal**/ Dry eyes/ ENT: **Normal**/Dry Mouth

Lungs: **Normal** Smokers Cough / COPD / Bronchitis / Asthma / Shortness of breath / Sogrens / Sarcoid

Heart: **Normal** Dizziness with standing / Heart attack / Angina / Rapid Heart beat / Irregular heart beat

Gastro Intestinal: **Normal** Intestinal, Large Bowel, Ulcer, Reflux Disease, Colitis, Irritable Bowel, Constipation

Kidney & bladder: **Normal**, Bladder incontinence, Stones

Endocrine: **Normal** / Diabetes / Hypothyroid: Use Medicines by mouth / Insulin / Sexual dysfunction

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



Blood / clotting / Lymphatic / Anemia, sickle cell, **Normal**Infectious Diseases: **Normal** / HIV / Hepatitis B / Hepatitis C / HerpesNeurologic: **Normal**, Neuropathy / Seizures / Parkinsons / Restless leg / Dizzy / Falls / Fainting / MSPsychiatric: **Normal**, Depression / Anxiety Neurosis / Panic disorder Bipolar / Personality DisorderMusculoskeletal: **Normal**, Fibromyalgia / Spasms / Morning Stiffness / Arthritis / Lupus / OsteoporosisCancer: **None**, Liver / Ovary / Lung / intestine / Bladder / Brain / Breast / Prostate

Do you have: Low Blood Pressure / Too Much or Too little Sweating / red or white skin discoloration

IV: Past Medical/Surgical, Test done in the past 1 year for the present problem and their duration

Disease (Circle)

Year Diagnosed Medications used for treatment

Diabetes / Cancer / COPD / Hepatitis C	
Seizures / Thyroid / B <sub>12</sub> / HIV / AF	
↑ Blood pressure / Heart Problems	
Syncope / falls / Chemo / Radiation	
Ulcer disease / Gastric Reflux / Hiatal Hernia	
Arthritis: Back Neck Knee Ankle Hip Shoulder	

List any surgeries? Did surgery help? Indicate by YES or NO (Circle)

Type of surgery & Hospital name & Doctors name	Helped	Approximate Date/Month/Year
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	

Which of the following tests you had in the past year? (If you have any reports please bring)

Name of the test	Approximate Date	Result of the Test as you understand
X-Rays		
CT / MRI scan		
EMG Report		
Consultations (Neurosurgery, Neurology)		
Brain Bone EKG scan		

PSYCHOLOGICAL EVALUATION

OARRS REPORT

PHARMACY REPORT

MEDICATION LIST

MEDICATION AGGREGMENT

URINE FOR TOX SCREEN

DAST

Family History: (paternal/maternal/siblings): Neuropathy / Diabetes / Back problems / Cancer / Drug related

Children (ages) (Supporting / Not supporting):

Sexual dysfunction Yes Secondary to / physical / psychological / medications / Diabetes No

If yes decrease / loss of desire / delay / unable to achieve orgasm / Loss of potency / unable to sustain erection / Trouble sweating



**Social History:** Single / Married / Divorced / Widowed / Living with \_\_\_\_\_

**Current Work status:** Working Full time / Part time / Retired / Disabled / Looking for **Last worked:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Job responsibilities** (Detailed) (Repetitive using wrist, shoulders, back, heavy lifting, typing, mental, pressure, crawling, bending etc.) \_\_\_\_\_

**Work place Ergo metrics** (Circle): Drive Long distance to work / Repetitive tasks / Twisting & lifting / Long sitting / Key Board Not working / Home maker / Sedentary / Function with some limitations / Not functioning / \_\_\_\_\_

**Education-** school / college \_\_\_\_\_

**Smoking:** Yes / No If yes Packs per day \_\_\_\_ Do you wish to Quit smoking ? Yes / No Quit \_\_\_\_\_

**Alcohol use:** No / Yes; If yes social / moderate / Used for \_\_\_\_\_ years Quit when \_\_\_\_\_

**Past street drug dependency / abuse:** No / Yes If Yes Use Drug Abuse Screening Test form \_\_\_\_\_

If yes since when/What/How long/Last time used \_\_\_\_\_

**Family History of Substance abuse:** No / Yes **History of Preadolescence sexual abuse:** No / Yes

**C:** Have you ever tried to cut down on your alcohol or drug use? Yes / No **A:** Do you get annoyed when commented about drinking or using drugs? Yes / No **G** Do you feel guilty about things you have done while drinking or using drugs? Yes / No

**E:** Do you need an eye-opener to get started in the morning? Yes / No

Have you had any fractures or dislocations of your bones or joints (excluding sports injuries)? Yes / No

Have you been injured in a traffic accident? Yes / No Have injured your head (Excluding sports injuries) Yes / No

Are you in fight or been assaulted while intoxicated Yes / No Have you been injured while intoxicated Yes / No

**Compensation:** No / Yes what type BWC –Self Insured / state / federal; social security: SSI / SSD \_\_\_\_\_

If any pain related to injury at work / personal injury: No / Yes

If yes; who was the employer / responsible party at the time of injury \_\_\_\_\_

Do you have more than one claim No / Yes Claim # \_\_\_\_\_

Do you use any assist devise (Circle if applicable): No / Cane / Walker / Crutch / Wheel chair / Scooter \_\_\_\_\_

Does your pain interfere with your ability to Carry Groceries / Climb stairs / bathe / dress / ability to use bath room / personal grooming

How would you rate your overall energy? (0-10) : \_\_\_\_ How would you rate your strength & endurance? (0/10 scale): \_\_\_\_

How would you rate your feeling of depression (0-10 scale): \_\_\_\_ How would you rate your feelings of anxiety (0-10) : \_\_\_\_

How would you rate your strength, endurance, energy and overall physical activity (0-10 scale) : \_\_\_\_

**Where can we get your Medical records. Provide names & phone numbers (MRI, X-rays notes etc):** \_\_\_\_\_

I listed all my medications in the **pain contract** form. The above information, I provided is accurate to the best of my knowledge.

**Signature of the patient.:** \_\_\_\_\_

Available data reviewed include:

1) Medical records from prior physicians reviewed include MRI Medications Progress notes Operative report X-rays Pharmacy bottles

2) UDS: Done Reviewed waiting for confirmation

3) OAARS Report: Reviewed Single group / Multiple Prescribers

4) \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/2012

**Reviewed, Assisted & Signed by Assistant** **Reviewed, corrected & Signed by Physician**  
B. K. Reddy, S. Erragolla, L. Mathai Dr. L. Goodson



Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / 2012

Please circle the following symptoms if you are experiencing Circle things apply to you?

Constipation. _____	Yes / No
Diarrhea. _____	Yes / No
Feeling full after only a few bites. _____	Yes / No
Nausea after eating. _____	Yes / No
Swollen abdomen. _____	Yes / No
Unintentional loss of more than 5% of body weight. _____	Yes / No
Vomiting of undigested food. _____	Yes / No
Blood pressure changes with the position. _____	Yes / No
Dizziness occurs when standing up. _____	Yes / No
Difficulty beginning to urinate. _____	Yes / No
Feeling of incomplete bladder emptying. _____	Yes / No
Urinary incontinence (lower flow incontinence). _____	Yes / No
Abnormal sweating (too much sweating or too little sweating). _____	Yes / No
Do you feel like Fainting, Dizzy, unsteady when walking, has fallen, has Balance problems, Vertigo _____	Yes / No
Heat intolerance. _____	Yes / No
Male impotency. _____	Yes / No
Rapid heart rate or abnormally slow Heart rate _____	Yes / No
Difficulty swallowing. _____	Yes / No
Do you have Lightheadedness or dizziness / Palpitations / Presyncope / Sense of weakness? _____	Yes / No
Do you suffer from Diabetes / Amyloidosis / Sarcoidosis / Irregular Heart beat / Fibromyalgia /	Yes / No
Are you taking insulin / Oral Diabetic Medications? _____	Yes / No
Do you have Blackouts and Seizures, unsteady when walking and climbing, Have Stroke affecting Balance? _____	Yes / No
Do you suffer from burning pain, tingling or numbness, Excessive sweating? _____	Yes / No
Does the fan blowing cause increase in your pain over your feet and hands? _____	Yes / No
Do you have the feeling of bugs crawling on your hands and feet? _____	Yes / No
Do you feel Dizzy, Feel like you may fall or have fallen in the past? _____	Yes / No
Does your feet turn purple when you stand and with swelling? _____	Yes / No
How much alcohol do you consume? _____	Yes / No
Do you suffer from Parkinson's disease, multiple sclerosis, HIV and AIDS, alcoholic neuropathy? _____	Yes / No
Diabetic neuropathy, Sjögren's syndrome, systemic lupus erythematosus, or post herpetic polyneuropathy? _____	Yes / No
Are you on Hypotensives, neuroleptics, hypnotics/anxiolytics, antiarrhythmics, antiparkinsons medications? _____	Yes / No
Have you been diagnosed with any cancer? Did you receive any chemotherapy or radiation? _____	Yes / No
Do you have loss of Balance while walking, objects spinning or turning around you, have tendency to fall? _____	Yes / No
Were you diagnosed with Hypothyroidism / Premature Menopausal symptoms / Guillain-Barré syndrome? _____	Yes / No
Did you Undergo Gastric bypass Surgery? _____	Yes / No
Do You suffer from Sleep Apnea / Sleep disorders / Asthma / COPD? _____	Yes / No
Do you suffer from Depression / Anxiety / Panic Disorder / PTSD / Attention Deficit Disorder? _____	Yes / No
Were you diagnosed to have Peripheral Neuropathy? _____	Yes / No
Do You use Cane, walker, wheel chair or any assistive devise? _____	Yes / No

Patient's Signature \_\_\_\_\_

Drs. B. K. Reddy / S. Erragolla / L. Matahi / P. Nuthakki / L. Goodson / PA Grace/ Crull/ Chasteen

Rx: AFT QSART 2 4 6 8 Sites EMG NCS BLE / LLE / RLE / BUE / RUE / LUE Fall Risk Testing

**Dayton  
Clayton  
Sidney  
Englewood**

**Corporate Headquarters**

1 Elizabeth Place Suite D, Dayton, Ohio 45408 Phone 937.222.2233 Fax 937.222.9665

1250 W. National Road Englewood, Ohio 45315 Phone 937.684.6452 Fax 937.222.9665

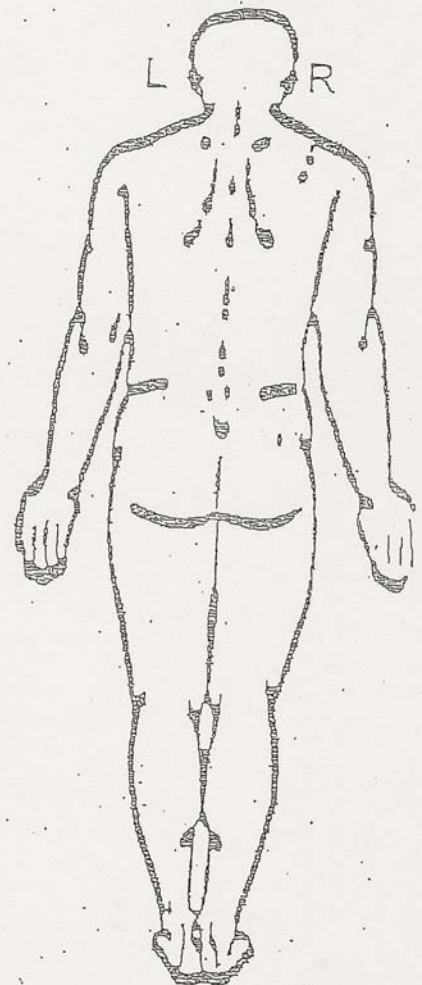
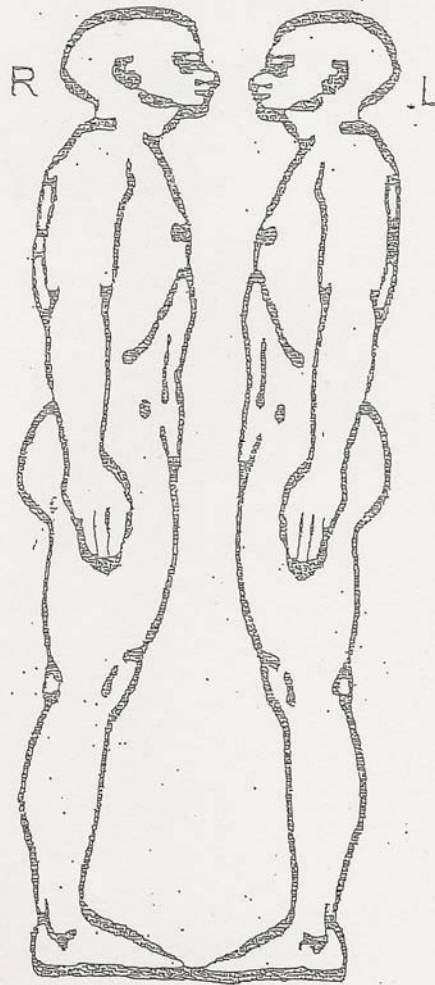
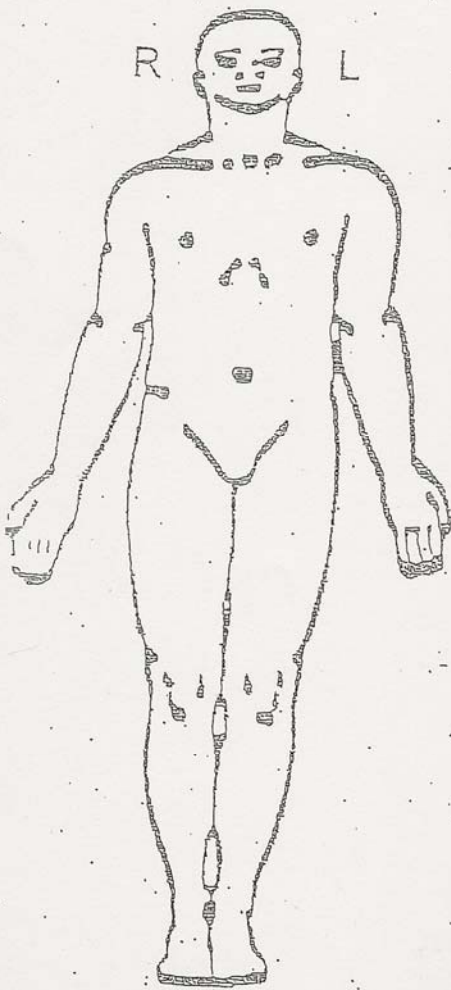
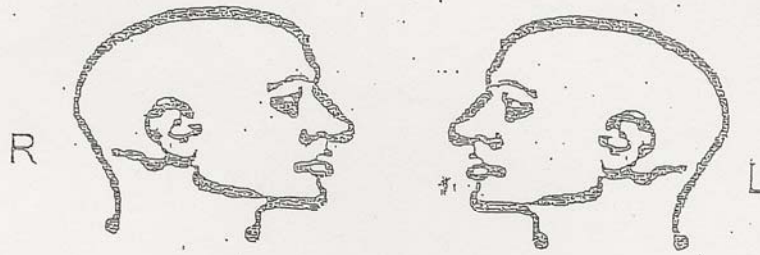
331 Sixth Avenue Sidney, Ohio 45365 Phone 937.497.9200 Fax 937.497.9300

9000 N. Main Street Englewood, Ohio 45315 Phone 937.222.2233 Fax 937.222.9665



Date \_\_\_\_\_

Please shade in with a pencil the areas where you feel pain.





## CURRENT MEDICATIONS AND PREVIOUSLY TAKEN PAIN MEDICATIONS

I am **currently taking** the following medications:

Name of the medication	Amount in Mg (How many mg/pill)	How often per day	Prescribing Physician

I have taken the following **Pain medications in the past**:

Name of the medication	Amount in Mg (How many mg/pill)	How often per day	Prescribing Physician

This is a true accounting of my medications.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / 201**2**

DAYTON PAIN CENTER, LLC.  
PATIENT DEMOGRAPHIC INFORMATION

Patient Name: \_\_\_\_\_ SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ /20\_\_\_\_\_

Sex: M / F Address: \_\_\_\_\_ City: \_\_\_\_\_ OH Zip: \_\_\_\_\_

Home Tel #: \_\_\_\_\_ Work Tel #: \_\_\_\_\_ Cell Tel #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status: Single / Married / Widowed Family Doctor: \_\_\_\_\_ Tel # \_\_\_\_\_ Fax \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's SSN#: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Employer Tel #: \_\_\_\_\_

Spouse's Emp. Address: \_\_\_\_\_ City: \_\_\_\_\_ OH Zip: \_\_\_\_\_

Who may we thank for referring you to us: \_\_\_\_\_ Tel #: \_\_\_\_\_

Referring Physician Name: \_\_\_\_\_ Tel #: \_\_\_\_\_ Fax # \_\_\_\_\_

Ref Physician Address: \_\_\_\_\_ City: \_\_\_\_\_ OH Zip: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

In case of emergency who may we contact: \_\_\_\_\_ Tel # \_\_\_\_\_

Is this visit due to injury: Yes / No Type of injury: Auto / BWC

Nearest relative not living with you: \_\_\_\_\_ Tel # \_\_\_\_\_

Nearest friend not living with you: \_\_\_\_\_ Tel # \_\_\_\_\_

Landlord Name: \_\_\_\_\_ Tel # \_\_\_\_\_

INSURANCE INFORMATION Financial Responsible party for this bill \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tel # \_\_\_\_\_ Insured Name: \_\_\_\_\_ SS# \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tel # \_\_\_\_\_ Insured Name: \_\_\_\_\_ SS # \_\_\_\_\_

Workers Compensation: Company: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone # \_\_\_\_\_ Claim # \_\_\_\_\_ Date Of Injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Case worker \_\_\_\_\_

AUTHORIZATION: I hereby authorize DAYTON PAIN CENTER, LLC. to release any information concerning my illness and treatments and that of my dependents. I also authorize payment of medical benefits of DPC for services rendered. I understand and agree (regardless of my status) that I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed all the answers. I CERTIFY this information is true and correct to the best of my knowledge. I will notify any changes in my status or the above information.

Responsible party Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ /20\_\_\_\_\_