ADVANCED INTERVENTIONAL PAIN MANAGEMENT, LLC

Last Name _____ **First Name**_____ **Appointment Date** ____/_____/_____

Male ☐ **Female** ☐ **Date of Birth** _____/_____/_____ **Ht**_____ft_____in **Wt**_____lbs

Pharmacy_____ **Location**_____

Referring Doctor_____

Current & Previous PAIN Medications: ☐ **None**

Name of Medication	Dose (mg), # per day	Pain relief?	Side effects?	Using now?
Tylenol (*Acetaminophen*)	_____mg, ___ per day	Yes / No / Some		Yes / No
Advil (*Ibuprofen, Motrin*)	_____mg, ___ per day	Yes / No / Some		Yes / No
Aleve (*Naproxen*)	_____mg, ___ per day	Yes / No / Some		Yes / No
	_____mg, ___ per day	Yes / No / Some		Yes / No
	_____mg, ___ per day	Yes / No / Some		Yes / No
	_____mg, ___ per day	Yes / No / Some		Yes / No
	_____mg, ___ per day	Yes / No / Some		Yes / No
	_____mg, ___ per day	Yes / No / Some		Yes / No

All OTHER Current Medications: ☐ **None**

Name of Medication	Dosage (mg)	# per Day

Medication Allergies: ☐ **None**

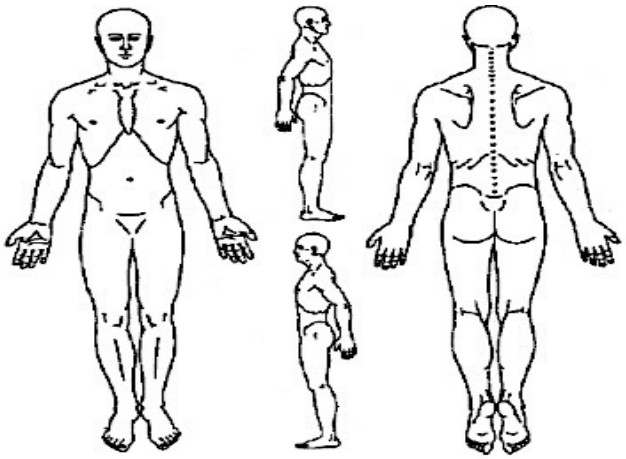
Name of Medication	Type of Reaction (Rash / Hives / Tongue or lip swelling / Shock / Other)

Surgeries and Hospitalizations: ☐ **None**

Surgery/Hospitalization	Date

WHERE IS YOUR PAIN?

-also indicate areas of radiating/shooting pain



How long have you had this pain: **_____ Weeks / Months / Years**

Describe the pain (circle all that apply):

Aching / Burning / Dull / Sharp / Shooting / Throbbing / Tight / Other: _____

How severe is the pain **on average**:

Minimal (0 1 2 3 4 5 6 7 8 9 10) Worst imaginable

Increases the pain:

Coughing / Sneezing / Driving / Lying down / Sitting / Standing / Walking / Weather changes /
Other: **_____**

Reduces your pain:

Cold / Heat / Lying down / Massage / Medications / Sitting / Standing / Changing position of neck or back /
Other: **_____**

Other symptoms associated with your pain:

Numbness / Tingling / Headache / Weakness / Muscle spasm / Loss of bowel/bladder control /
Other: **_____**

Is this the result of an accident? (specify): **Motor Vehicle / Worker's Compensation**

Date: ____/____/_____ (Brief description) _____

Interference with your daily activities: **Mild / Moderate / Severe / Very severe**

Do you use any of the following: **Cane / Walker / Wheelchair / Back brace / Neck collar**

Previous treatments:	Dates:	Did it help?	Duration of pain relief?
Acupuncture	_____	Yes / No / Some	_____ days / weeks / months / years
Heat / Cold Application	_____	Yes / No / Some	_____ days / weeks / months / years
Chiropractic Manipulations	_____	Yes / No / Some	_____ days / weeks / months / years
Massage	_____	Yes / No / Some	_____ days / weeks / months / years
Physical Therapy	_____	Yes / No / Some	_____ days / weeks / months / years
-Ultrasound Therapy	_____	Yes / No / Some	_____ days / weeks / months / years
-Electrical Stimulation (TENS)	_____	Yes / No / Some	_____ days / weeks / months / years
Injections	_____	Yes / No / Some	_____ days / weeks / months / years
-Epidural Injections	_____	Yes / No / Some	_____ days / weeks / months / years
-Nerve Blocks	_____	Yes / No / Some	_____ days / weeks / months / years
-Other	_____	Yes / No / Some	_____ days / weeks / months / years
Home exercises (stretching, etc.)	_____	Yes / No / Some	_____ days / weeks / months / years