# MWAG PAIN MANAGMENT

## PATIENT HISTORY

***Accurately completing the intake below will help us to better understand and assess your pain, and to begin the best possible treatment program for you. Please be assured that our records are strictly confidential and no one outside of your health care team is permitted to review your case record without your written consent.***

## SECTION 1 - BACKGROUND INFORMATION

***Patient:***

Last Name _____First Name _____ Middle Initial ____

Address _____City _____State _____

Zip Code _____ Phone #_____

Email _____

Date of Birth _____ Age_____

Driver's License No_____ State Issued_____

Social Security No_____

Height _____ Weight _____

Reason for Today's Visit:

_____

_____

_____

_____

## SECTION 2 – EMERGENCY CONTACT

Name _____ Relationship _____

Address _____ City _____ State _____

Zip Code _____ Phone No_____

## SECTION 3 - EMPLOYMENT HISTORY

Do you work? □ Yes □ No

***If No,*** *last occupation or work experience*

_____

***If Yes,*** *please complete the following:*

Employer_____ Title_____

Address_____ City_____ State _____

Zip Code_____ Phone No_____ Fax No_____

Length of Employment _____ Full-Time _____ Part-Time _____ Self-Employed_____

## SECTION 4 - INSURANCE INFORMATION

***Primary Insurance***

_____

***Address***_____ ***City***_____ ***State***_____

***Zip Code***_____ ***Phone No***_____ ***Group #***_____

***Account #***_____ ***Issuer #***_____ ***Plan*** _____

***Insured's***

***Name***_____

***Secondary Insurance***

_____

***Address***_____ _____ ***City***_____ ***State***_____

***Zip Code***_____ ***Phone No***_____ ***Group #***_____

***Account #***_____ ***Issuer #***_____ ***Plan*** _____

***Insured's Name***

_____

If you are a Medicare or Medicaid subscriber, please give #_____

## SECTION 5 - PROVIDER INFORMATION

**Primary Care Physician (PCP)**

***Name***_____
***Address*** _____
***Phone***_____
***Fax***_____

**Referring Physician (RP)** *(Complete only if different from Primary Care Physician)*

***Name*** _____
***Address*** _____
***Phone*** _____
**Fax** _____

**Please list other physician specialists you have seen:**
***Name***_____ ***Reason***_____
***Name***_____ ***Reason***_____
***Name***_____ ***Reason***_____

Do you receive Workmen's Compensation: ☐ Yes ☐ No
***If Yes****, please complete the following:*
***Insurance Carrier:*** _____
***Case Manager's Name*** _____
***Case Manager's Phone:*** _____ ***Fax:***_____
***Case Manager's Address:*** _____

Do you receive Disability Compensation? ☐ Yes ☐ No
***If Yes,*** *Insurance Carrier's Name:* _____

Is an attorney involved for your disability or injury? ☐ Yes ☐ No
***If Yes,*** *Attorney's Name:* _____

## SECTION 6 - PAIN ASSESSMENT

1. Did an injury cause your pain? ☐ Yes ☐ No

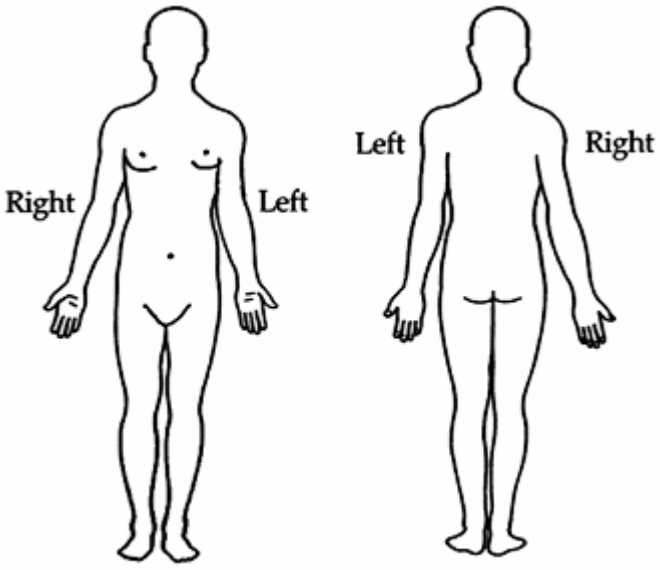
***If Yes****, how long the pain has the pain bothered you (give the date/year) and describe the injury:*

_____

2. If you are employed, does your pain interfere with your work? ***If yes,*** *please explain:*

_____

Please fill in the "Pain Diagram" below to let us know where your pain is and where it hurts the worst. Shade or color the areas on your body where you feel pain. Mark **Severe Locations with "O"s** and use an **"X" where it is the W*orst.***




Mark the area(s) where you feel pain.

**Pain is a *subjective* experience. Please use this scale to help us understand the severity of your suffering.**

**1-4** Pain that doesn't prevent you from participating and completing daily activities.
**5** Pain that makes you feel you need medication, but doesn't force you to stop your activity. You can delay taking medicine so the current task(s) can be completed without interruption.
**6-7** Pain that is severe enough to stop any tasks and necessitates immediate medication.
**8-9** Pain so severe and debilitating that someone else has to get your medication(s) for you.

**10** Absolutely the worst pain. You are completely disabled.

3. Which face shows how much you hurt ***now***? Put an **"X"** on the face.


4. Which face shows how much you hurt with your ***worst*** pain? Put an **"X"** on the face.


5. Which face shows how much you hurt when your pain is at its ***least***? Put an **"X"** on the face.


6. Which face shows how much you hurt on ***average***? Put an **"X"** on the face.

7. Indicate whether the following activities make your pain ***better*** or ***worse***?

| Activity | Better | Worse | No Change |
|---|---|---|---|
| Pain Pills | | | |
| Alcohol | | | |
| Bending | | | |
| Pushing | | | |
| Sex | | | |
| Cold/Ice | | | |
| Heat | | | |
| Dampness | | | |
| Standing | | | |
| Walking | | | |
| Staying Busy | | | |
| Lifting | | | |
| Stress | | | |
| Moving Around | | | |

8. To avoid worsening of your pain, please describe your limits:

How far can you walk? _____ How long can you stand? _____
How much can you lift? _____ How long can you sit? _____

Because of your pain, what percentage of time is lost from:

| | Work | Housework | Social Activities | Sleep | Recreational Activities | Sexual Relations |
|---|---|---|---|---|---|---|
| Time Lost | | | | | | |

9. Circle *all* words that describe your pain *(Circle more than one, if necessary):*

| | | |
|---|---|---|
| Aching | Sharp | Penetrating |
| Throbbing | Tender | Nagging |
| Shooting | Burning | Numb |
| Stabbing | Exhausting | Miserable |
| Gnawing | Tiring | Unbearable |

Other (please list):_____

Have you seen other doctors for your pain? □ Yes □ No

***If yes,***

Physician Name: _____
Address: _____
City/State/Zip: _____
Phone: _____

10. Have you had surgery for your pain? ☐ Yes ☐ No
**If yes,** please list surgeries:

| Surgery | Date | Surgeon | Results |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

11. Have you had any of these tests?

X-Rays CAT Scan MRI Scan Bone Scan Myelogram EMG Nerve Test

| Test | Date | Place | Results |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Other *(Please List)* _____

12. What other medical problems do you have?

☐ Hypertension ☐ Heart Disease ☐ Asthma/Emphysema ☐ Seizures/Stroke ☐ Unexplained weight loss

_____
_____
_____
_____
_____
_____

13. Do you have any allergies? ☐ Yes ☐ No ***If yes,*** to what, and what was your reaction?

| **Allergy** | **Reaction** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

14. Are you allergic to any of the following?

Iodine ☐ Yes ☐ No
Tape ☐ Yes ☐ No
X-ray dye ☐ Yes ☐ No

15. What medications do you take?

| Name of Medication | Reason Prescribed | Dosage | How Often | Date Started | Prescribing Doctor |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

16. **Social History**:

Martial Status: ☐ Single ☐ Divorced ☐ Married
Who lives with you? _____
Do you smoke? ☐ Yes ☐ No How many packs per day? _____ For how long?
Do you drink alcohol? ☐ Yes ☐ No _____ # of drinks when you drink?
Do you drink alcohol daily? ☐ Yes ☐ No
What types of alcohol do you drink? _____

17. **Family History:**

Do any medical problems run through your family? ☐ Yes ☐ No
If so, what? _____

18. Have you had any problems with misuse of prescription medications, alcohol, street drugs or other substances? ☐ Yes ☐ No
19. What is your goal for pain control?

_____
_____
_____
_____
_____
_____

***Please feel free to use the remaining space to add any additional information that you believe will be pertinent to your evaluation.***

_____
_____
_____
_____
_____
_____
_____

***Thank you for taking the time to fill out this questionnaire. Your participation will help us determine the best course of treatment for you.***