COMPREHENSIVE PAIN MANAGEMENT

PATIENT INFORMATION FORM

Name: _____

Date: ___/___/____ History of ____/____/____ Reviewed

HISTORY

Chief Complaint: _____

Where is your pain located? _____

When during the day do you have your pain? _____

What makes your pain worse? _____

What makes your pain better? _____

Describe your pain (circle those that apply): Sharp, Burning, Shooting, Achy, Knife-Like, Twisting, Pressure, Lancinating, Tooth-Ache, Deep, Heavy, Gnawing

How severe is your pain? _____
0 (no pain); 1-2 (tolerate without medications); 3-4 (tell someone about my pain, take Aspirin or Motrin); 5-6 (mild narcotic, ex. Tylenol #3); 7-8 (go to the ER, take strong narcotics); 9-10 (admission to hospital for pain control)

PAST HISTORY:

Any New medication allergies or other allergies since last visit ?_____

Are you taking any new medications since last visit? _____

_____

Have you had any new illnesses, injuries, surgeries or hospitalizations since last visit? _____

_____

Any change in your FAMILY HISTORY since our last visit (parents, siblings, children, grandparents) ?

_____

Any change in your SOCIAL HISTORY since our last visit (marital status, employment, drugs, ETOH, tobacco, education) ?

_____

ROS: Constitutional = wt change, weakness, fatigue, fever
Eyes= vision, glasses, pain, tearing, double vision
Earns, Nose, Mouth, Throat,= hearing, tinnitus, vertigo, pain, sinus, colds, gums, sore throat
Cardiovascular = High blood pressure, rheum fever, murmurs, shortness of breath, chest pain, palpitations
Respiratory = cough, sputum, coughing up blood, wheezing, asthma, bronchitis, chest pain
Gastrointestinal = trouble swallowing, heartburn, vomiting, diarrhea, indigestion, pain, blood, stool changes
Genitourinary = pain with urination, urinating at night, blood in urine, urgency, hesitancy, incontinence
Musculoskeletal = joint pain/ stiffness, cramps, back or neck ache, weakness, loss of range of motion
Skin = rash, lumps, itching, dryness, color change, hair changes, nail changes
Neurological = fainting, blackouts, seizures, paralysis, weakness, numbness, memory loss
Psychological = nervousness, tension, mood changes, depression, anxiety
Endocrine = heat or cold intolerance, sweating, thirst, hunger, change in urination
Hematology/ Lymphatics = bruising, bleeding, transfusion reactions
Allergies/ Immunological = drug, product or other allergies, childhood immunizations

History Level	HPI	ROS	PFSH
Problem Focused	Brief 1-3	None	None
Expanded Problem Focused	Brief 1-3	1 pert to problem	None
Detailed	Extended 4 or more	Extended 2-9	Pert 1
Comprehensive	Extended 4 or more	Complete 10 or more	Complete 2 or 3

NEUROLOGICAL EXAMINATION FORM

Vital Signs: BP ___/___ Pulse: _____ RR: _____ Temp: _____ HT/WT: _____/_____

System/ Body area	Pertinent Positives & Negatives
Constitutional: □ well developed, well nourished, in no acute distress	
Eyes: □ Disc flat, no hemorrhages or exudates noted.	
Cardiovascular: □ No Carotid Bruits □ RRR , no murmurs □ No peripheral edema, varicosities, skin warm	
Musculoskeletal: □ Gait coordinated and smooth. □ Muscle strength normal (5 out of 5) in both upper and lower extremities.. □ Muscle tone normal in both upper and lower extremities without spasticity, atrophy, cogwheeling or abnormal movements.	
Neurological: □ Alert and oriented x3 □ Recent and remote memory intact □ Concentrates well, not easily distracted □ Speech: smooth and clear □ Aware of current events □ CN II = Visual fields full of confrontation, vision intact □ CN III, IV, VT= PERRLA, EOMs intact □ CN V = B/L corneal reflexes and facial sensation intact. □ CN VI = Facial movement and strength symmetrical □ CN VIII = B/L hearing with tuning fork equal, whispered voice/finger rub intact □ CN IX = Upward palate movement and pharyngeal muscles contraction, uvula midline. Gag reflex intact. □ CN XI = Normal bilateral shoulder shrug . □ CN XII = Tongue protrusion midline, symmetrical without atrophy, firm pressure. □ Bilateral superficial light touch & pain sensation intact. □ Deep tendon reflexes in both upper and lower extremities intact and normal. Babinski and Hoffman reflexes negative. □ Finger to nose & heel to shin coordination are smooth and accurate	

NECK
ROM
Spasms
Pain/Palp
Spurling's
TP's
Facets
Post Elements

MIDBACK
ROM
Spasms
Pain/Palp
TP's
Facets
Post Elements

LOW BACK
ROM
Spasms
Pain/Palp
TP's
Facets
Post Elements
SU Shear
SU PA
PSI
Patrick's
GT
SLR

SHOULDER
ROM
Neers
Hawkin's
GT
Bicep Tendon
Resist AB
Post Elements

KNEE
ROM
Ant Draw
Lockman
VR/VL
Joint Line
Crepitus
McMurray's
Apply
Patella
TT/ Anserine Bursa

Exam Level	Number of Bullets/Checks
Problem Focused	Any 1 to 5
Expanded Problem Focused	At least 6
Detailed	At least 12
Comprehensive	All; Doc all shaded/bolded and at least 1 in unshaded/unbolded boxes

DECISION MAKING

Decision Level	Dx & Management	Risk	Data
Straightforward	1	Minimal	1
Low Complexity	2	Low	2
Moderate Complexity	3	Moderate	3
High Complexity	4 or more	High	4 or more

ESTABLISHED OFFICE OUT PT E&M CODES (requires 2 of 3 key components)

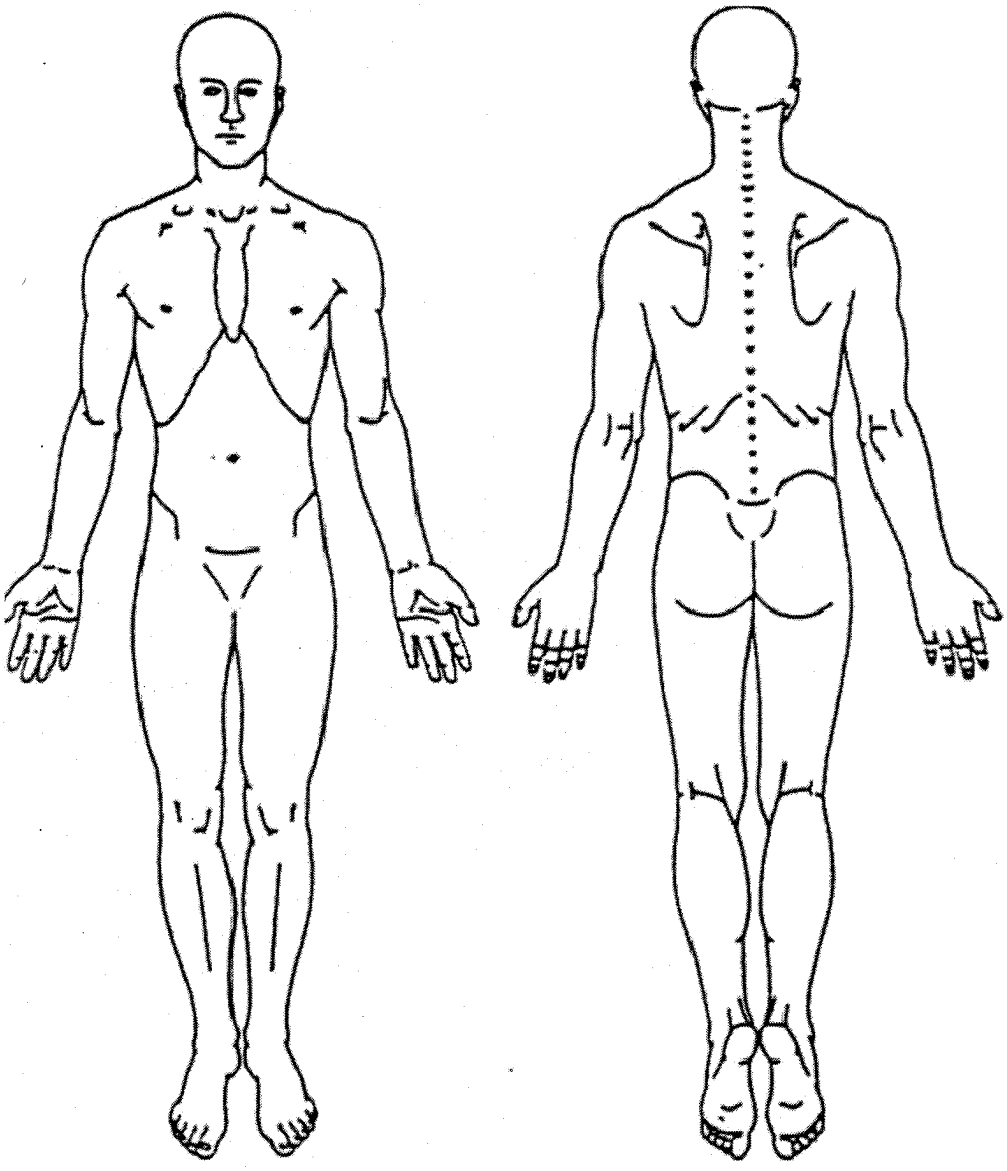
History	N/A	Problem Focused	Expended	Detailed	Comprehensive
Exam	N/A	Problem Focused	Expended	Detailed	Comprehensive
Decision Making	N/A	Straightforward	Low Complexity	Mod Complexity	High Complexity
Codes	99211	99212	99213	99214	99215

Patient Name: _____ Date: _____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. You may use more then symbol. Rate the intensity of all symbols 1-10 with 1 being mild and 10 intolerable.

Numbness xxxxxxx **Pins & Needles /////////** **Burning ^^^^^^**

Ache ———— **Other >>>>>>>>** **Stabbing <<<<<<<**



PAIN

1. Please circle the number that best describes your level of pain right now.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

2. Please circle the number that best describes the average pain you have experienced since your last visit.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

3. Please circle the number that best describes the worst pain you have experienced since your last visit.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

4. Please circle the number that best describes the least pain you have experienced since your last visit.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

5. Please circle the percentage of pain relief that you have obtained since your last visit.

   No relief 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Complete Relief

6. Since last visit, please circle the number of emergency room visits that you have had due to pain.

   0 1 2 3 4 5 or more

7. Since last visit, please mark any reason for which you had to call the Pain Treatment Center.

   □ uncontrolled pain □ lab/radiology results □ medication changes

   □ medication side effects □ prescription refills

FUNCTION

Since your last visit how much has you pain interfered with the following areas:

8. **Ability to work:**

   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

9. **Ability to sleep:**

   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

10. **Ability to participate in social activities:**

    Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

11. **Ability to do household chores:**

    Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

12. **Relationship with family:**

    Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

13. **Sexual activities:**

    Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

14. **General Mood:**

    Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

15. Do you need to lie down during the day due to pain? □ Yes □ No

16. If so circle how many times on average you need to lie down during the day. 1 2 3 4

17. Do you wake up during the night because of pain? □ Yes □ No

18. Do you feel rested in the morning? □ Yes □ No

19. Please circle the average number of hours you sleep at night?

    0 1 2 3 4 5 6 7 8 9 10

MEDICATIONS

20. Please mark any medications that you may be on and write in the daily dosage:

    □ Oxycontin □ MS Contin □ Methadone □ Fentanyl Patch □ Ora morph □ Kadian

    Dosage: _____

    □ Oxycodone □ Percocet □ MSIR

    Dosage: _____

    Please list any other medications with dosages that you are taking: _____

    _____

    _____

21. Please circle the percentage of pain relief that you get from your medications.

No Relief 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Complete Relief

22. Please mark any bothersome side effects that you may have experienced since your last visit.

□ nausea □ constipation □ itching □ sleepiness
□ vomiting □ urine problems □ mood changes □ inability to concentrate

23. Please circle the statement that best describes how satisfied you are with your care at the Pain Treatment Center.

Not Satisfied Somewhat satisfied Satisfied Very satisfied Completely

Additional Comments

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature _____

Thank you for completing this form