OREGON
INTERVENTIONAL
PAIN CONSULTANTS

PATIENT FIRST NAME: _____LAST NAME _____

DATE OF VISIT: _____PROVIDER: Shea OR Dr. Rosenblum

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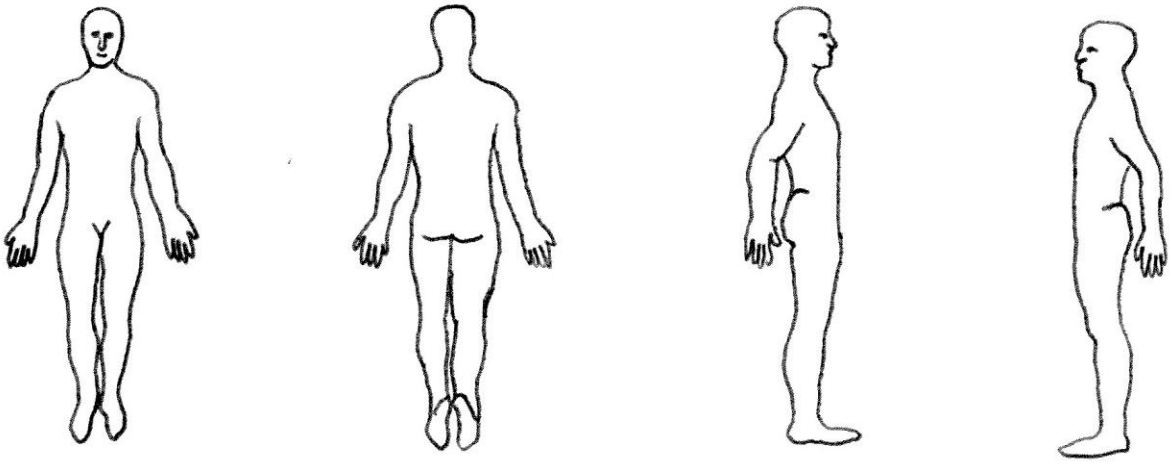
1. WHAT IS THE PRIMARY REASON FOR YOUR VISIT TODAY?

_____ Scheduled, Routine Follow-Up
_____ Injections / Procedure
_____ Urgent Issue
_____ New Problem, New Illness or New Injury

2. HOW WOULD YOU DESCRIBE YOUR SYMPTOMS SINCE YOUR LAST VISIT?

_____ Back Pain
_____ Bone Pain
_____ Headache
_____ Joint Pain
_____ Joint Stiffness
_____ Limb Pain
_____ Muscle Spasms
_____ Nausea/Vomiting
_____ Neck Pain
_____ Numbness
_____ Weakness
_____ Weight Loss
Other: _____
_____
_____
_____
_____
_____

3. CURRENT LOCATION OF PAIN: (SHADE IN THE PAINFUL AREAS ON THE DIAGRAM BELOW)



4. ON A SCALE OF 0-10, WHAT IS YOUR CURRENT PAIN LEVEL? (CIRCLE)

0 1 2 3 4 5 6 7 8 9 10

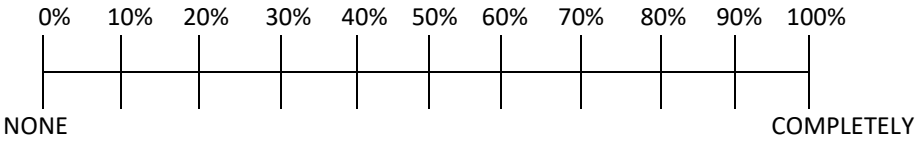
NO PAIN WORST PAIN

5. WHAT HAS BEEN YOUR AVERAGE PAIN LEVEL OVER THE LAST MONTH? (CIRCLE)

0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST PAIN

6. HOW MUCH IS YOUR CURRENT PAIN MANAGEMENT THERAPY REDUCING YOUR PAIN? (CIRCLE)



7. DOES YOUR CURRENT PAIN MANAGEMENT TREATMENT IMPROVE YOUR FUNCTION FOR THESE SPECIFIC THINGS?

	Yes	No
General Activity		
Mood		
Walking		
Normal Work (Includes work outside the home & housework)		
Relationships with other people		
Enjoyment of life		
Sexual Activity (If not applicable, please select No)		
Sleep		

8. ANY HOSPITALIZATIONS OR ER VISITS SINCE YOUR LAST APPOINTMENT? (NOT PREVIOUSLY DISCLOSED):
____ NO OR ____ YES **IF YES, PLEASE EXPLAIN**: _____

9. ARE THERE ANY MAJOR **NEW** PROBLEMS OR SIDE EFFECTS WITH YOUR CURRENT TREATMENT?

____ Nausea ____ Itching ____ Confusion Other: _____
____ Vomiting ____ Dizziness ____ Sweating _____
____ Constipation ____ Sleepiness ____ Anxiety _____
____ Dry Mouth ____ Shortness of Breath

10. HOW WOULD YOU DESCRIBE THE QUALITY OF YOUR SLEEP EACH NIGHT?
_____ POOR _____ FAIR _____ GOOD _____ EXCELLENT

11. DO YOU HAVE ANY **NEW** FEVERS, NIGHT SWEATS, INTOLERANCE TO HEAT/COLD, UNANTICIPATED WEIGHT CHANGES?
____ NO OR ____ YES **IF YES, PLEASE EXPLAIN**: _____

12. DO YOU HAVE ANY **NEW** MUSCLE OR BONE DISORDERS, PROBLEMS WITH JOINT/ARTHRITIS, TROUBLE WITH ARMS AND/OR LEGS?
____ NO OR ____ YES **IF YES, PLEASE EXPLAIN**: _____

13. DO YOU HAVE A HISTORY OF STROKE, SEIZURE, NEUROPATHY, NERVE INJURY OR ANY **NEW** OTHER NEUROLOGIC SYMPTOMS?
____ NO OR ____ YES **IF YES, PLEASE EXPLAIN**: _____

14. DO YOU HAVE ANY **NEW** ABDOMINAL PAIN, STOMACH ULCERS, HIATAL HERNIA, BOWEL PROBLEMS, BLEEDING, GALLBLADDER PROBLEMS, HEPATITIS, OR LIVER PROBLEMS?

____ NO OR ____ YES **IF YES, PLEASE EXPLAIN**: _____

15. DO YOU HAVE A **NEW** COUGH, HAVE A HISTORY OF ASTHMA, COPD, CHRONIC BRONCHITIS, OR SHORTNESS OF BREATH?

____ NO OR ____ YES **IF YES, PLEASE EXPLAIN**: _____

16. DO YOU HAVE **NEW** CHEST PAIN, HAVE A HISTORY OF HEART ATTACK, BLOOD FLOW PROBLEMS, IRREGULAR RYTHYM, AND/OR HIGH BLOOD PRESSURE?

____ NO OR ____ YES **IF YES, PLEASE EXPLAIN**: _____

17. ARE YOU TAKING ANY BENZODIAZEPINES? (EXAMPLE: DIAZEPAM (VALIUM), LORAZEPAM (ATIVAN) OR ALPRAZOLAM (XANAX))

____ NO OR ____ YES **IF YES, PLEASE EXPLAIN**: _____

18. LIST ANY **NEW** MEDICATION CHANGES SINCE YOUR LAST APPOINTMENT (**NOT PREVIOUSLY DISCLOSED**):

Name of Medication	Dose (mg)	How many?	How often?	What is this medication for?

19. LIST ANY **NEW** ALLERGIES (**NOT PREVIOUSLY DISCLOSED**):

Name of Medication	What reaction did you have to this medication?

20. CURRENT PHARMACY NAME: _____ LOCATION: _____