SPINAL DIAGNOSTICS AND THERAPEUTICS INITIAL VISIT

(Physicians- Dictate Template Type)

USE PATIENT PLATE

University of California, Davis
Medical Center
Sacramento, California
UCD Pain Management Center Worksheet

Please complete this form today before your first appointment at the University of California, Davis Medical Center Anesthesia Pain Management Center. Your careful answers will help us to understand your pain problem and design the best treatment program for you.
You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g., Workman's Compensation Claims)

Requesting Physician _____

Primary Care Physician (if not the same) _____

Patient Information

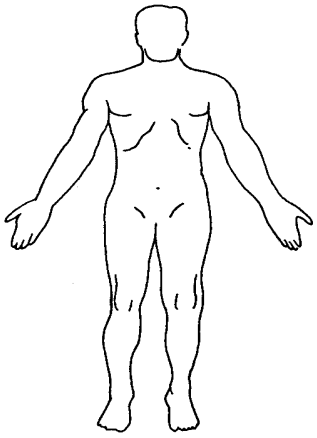
_____ Age ____ Sex: M ☐F☐
Last Name First M.I.

ABOUT YOUR PAIN (Chief Complaint)

What is the main problem for which you are seeking treatment at the Pain Management Center?

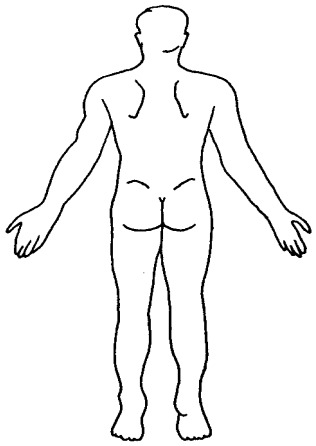
PAIN LOCATION

Right



Front

Left



Back

Right

Please mark the location(s) of your pain on the diagrams above with an "X." If whole areas are painful, please shade in the painful area.

ONSET OF PAIN and DURATION

When did your current pain start? _____

Briefly describe how your current pain started? _____

SPINAL DIAGNOSTICS AND THERAPEUTICS INITIAL VISIT

TIMING OF PAIN

How often do you have your pain (please check one)?

- ☐ Constantly (100% of the time)
- ☐ Frequently (75% of the time)
- ☐ Intermittently (50% of the time)
- ☐ Occasionally (25% of the time)

PAIN QUALITY

How would you describe the pain (choose as many adjectives as are applicable)?

☐burning	☐sharp	☐cutting	☐throbbing
☐cramping	☐numbness	☐dull, aching	☐pressure
☐pins and needles	☐shooting	☐electric-like	☐other

RATE YOUR PAIN INTENSITY

If the number 0 is "no pain" and the number 10 is the "worst pain imaginable", what number describes your pain **RIGHT NOW –** (circle a number below)

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Imaginable

Please circle the one number that best describes your pain **on average over the last week**.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Imaginable

Please circle the one number that best describes your pain at its **least** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Imaginable

Please circle the one number that best describes your pain at its **worst** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Imaginable

RELIEVING AND AGGRAVATING FACTORS

How do the following affect your pain (please check one for each item)?

ACTIVITY	Improves	Worsens	No Change
Lying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Exercise (if applicable)	☐	☐	☐
Medications	☐	☐	☐
Relaxation	☐	☐	☐
Thinking about something else	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Urination	☐	☐	☐
Bowel movements	☐	☐	☐

CURRENT MEDICATIONS: Patients will be a given current medication sheet to fill out or update. If you have not received a current medication sheet, please request one at the front desk of the clinic.

SPINAL DIAGNOSTICS AND THERAPEUTICS INITIAL VISIT

BLOOD THINNERS: Please list any **Blood Thinning** or **Clot Preventing Medications** (like Coumadin, Plavix, Aspirin, Motrin, Naprosyn, Daypro, Ticlid, etc.) that you have taken in the last 7 days

1	2
3	4

OPIOID MEDICATIONS: If you are taking medications such as **Vicodin, Percocet, Dilaudid, Fentanyl, MSContin, Oxycontin, etc**, list activities (chores, exercise, walking longer distance, shopping, housework, etc.) you **CAN DO NOW** that you **COULDN'T DO BEFORE** being prescribed opioids.
Write **'Do Nothing New'** if you cannot do anything more since being prescribed opioids.

1)	4)
2)	5)
3)	6)

Have you had an **infection, fever or chills** in the last 7 days? No ☐ Yes ☐

Have you taken **antibiotics** in the last 7 days? No ☐ Yes ☐

Have you or any blood relative had a **Problem with Anesthesia/Sedation in the past**? No ☐ Yes ☐
If yes, describe.

_____

How many hours has it been since you **last** had any **solid food** _____hrs. or **clear liquids**_____hrs.

Do you have a history of ☐**stridor,** ☐**snoring, or** ☐**sleep apnea**?
*If **Yes**, check the appropriate box and describe*

_____

Female Patients: Is there any possibility that you could be pregnant? No ☐ Yes ☐

PREVIOUS DIAGNOSTIC STUDIES - Please indicate approximate date and results, if known:

MRI
CT
X-Rays
EMG

PRIOR INJECTION PROCEDURES **(Physicians- Dictate Narrative of Prior Procedures, Dates, and Results)**
Please list prior injections and procedures with dates and state whether they were helpful or not:

1)
2)
3)
4)

SPINAL DIAGNOSTICS AND THERAPEUTICS INITIAL VISIT

Legal issues

Are you currently involved in litigation related to your pain complaint? ☐Yes ☐No

Have you ever been arrested or had other legal problems? ☐Yes ☐No
If Yes Explain:_____

Have you filed a Workers' compensation claim related to your pain complaint? ☐Yes ☐No

Psychological treatment

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain complaint? ☐Yes ☐No

If yes, explain _____

Effect of Pain on Employment Status

Has your employment status been affected by the present pain condition? ☐Yes ☐No

Are you currently unemployed because of your present pain condition? ☐Yes ☐No

If unemployed, how long have you have been off work because of pain: (If employed, do not answer)

_____ **months** _____ **years**

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REVIEW OF SYSTEMS AND PAST, FAMILY, AND SOCIAL HISTORY

PREVIOUS PAIN TREATMENTS

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

Treatment	Date (approx)	Excellent Relief	Moderate Relief	No Relief
☐ Hospital bed rest		☐	☐	☐
☐ Traction		☐	☐	☐
☐ Surgery		☐	☐	☐
☐ Hypnosis		☐	☐	☐
☐ Acupuncture		☐	☐	☐
☐ Nerve block / injections		☐	☐	☐
☐ TENS		☐	☐	☐
☐ Physical therapy		☐	☐	☐
☐ Exercise		☐	☐	☐
☐ Heat treatment		☐	☐	☐
☐ Biofeedback		☐	☐	☐
☐ Psychotherapy		☐	☐	☐
☐ Chiropractic		☐	☐	☐
☐ Other		☐	☐	☐

REVIEW OF SYSTEMS

Please check any of the following signs or symptoms that are currently experiencing.	YES		Office Use Only
fever or chills?	☐		Constitutional
unplanned weight loss?	☐		
double or blurred vision?	☐		Eyes
hearing loss?	☐		ENT
difficulty swallowing?	☐		
bleeding gums?	☐		Hematologic/Lymph
low platelet count?	☐		
heat intolerance?	☐		Endocrine
cold intolerance?	☐		
thyroid problems?	☐		
skin rash?	☐		Integumentary
shortness of breath?	☐		Resp
wheezing?	☐		
palpitations (awareness of fast heart)?	☐		Cor
chest pain?	☐		
constipation?	☐		GI
abdominal pain?	☐		
nausea?	☐		
vomiting?	☐		
diarrhea?	☐		
sexual dysfunction?	☐		GU
urinary retention or difficulty urinating?	☐		
back pain?	☐		Musculoskeletal
neck pain?	☐		
joint pain (knee, elbow, hip etc.)?	☐		
muscle pain?	☐		
loss of consciousness or blackouts?	☐		Neuro
memory loss?	☐		
muscle weakness?	☐		
seizures?	☐		
trouble walking?	☐		
dizziness?	☐		
drowsiness?	☐		
excessive fatigue?	☐		
difficulty falling or remaining asleep?	☐		Behav
loss of interest in hobbies or other activities?	☐		
difficulty concentrating?	☐		
feelings of guilt?	☐		
feeling depressed?	☐		

FAMILY LIFE - LIVING ARRANGEMENTS: (Check all that apply)

"I currently":

- ☐ - live with my spouse
- ☐ - live alone
- ☐ - live with an adult companion
- ☐ - live with my partner
- ☐ - live with my son
- ☐ - live with my daughter
- ☐ - live in an assisted living facility
- ☐ - live in an extended care facility
- ☐ - live in a skilled nursing facility
- ☐ - live in a nursing home
- ☐ - live in a boarding home
- ☐ - live in a foster home
- ☐ - live in an adult home
- ☐ - am homeless
- ☐ - live in a correctional facility

PAST MEDICAL HISTORY

Have you had any of the following health problems (please check all that apply)?

☐ Arthritis	☐ Depression	☐ Mental Illness or Psychological Problems
☐ Angina	☐ Diabetes	☐ Migraine or other Headaches
☐ Asthma	☐ Emphysema	☐ Other Kidney Disease
☐ Back Pain	☐ Fainting Spells	☐ Pancreatitis
☐ Bleeding Problems	☐ Heart Attack	☐ Seizures or Epilepsy
☐ Bowel Disease	☐ Hepatitis	☐ Stroke
☐ Cancer (type?)	☐ Kidney infection	☐ Thyroid Problems
☐ Chronic Allergies	☐ Liver Disease or Cirrhosis	☐ Ulcers
☐ Other		

Please explain any medical conditions checked above: _____

_____

_____

☐Other; please specify _____

_____

ALL SURGERIES (type of operation and approximate date):

Name of Surgery	Date

FAMILY HISTORY:

Have any blood relatives had any of the following health problems?
(please check all that apply and indicate the relation, such as parent, sibling, aunt, children, etc.)?

Health Problem	Affected Blood Relative (Sister, Brother, Mother Father, Aunt, Uncle, Maternal vs Paternal Grandparents, etc.
☐ Alcohol or Drug Abuse	
☐ Allergies	
☐ Anesthesia Problems	
☐ Arthritis	
☐ Asthma	
☐ Blood Disease	
☐ Cancer	
☐ Diabetes	
☐ Genetic Problems	
☐ Gastrointestinal Disease	
☐ Genitourinary	
☐ Heart Disease	
☐ High Blood Pressure / Hypertension	
☐ High Lipids	
☐ Psychiatric Problems	
☐ Stroke	
☐ Thyroid Problems	
☐ Other	

Tobacco Use

Do you or did you ever smoke cigarettes or use tobacco? ☐Yes ☐No
How many years have you or did you smoke? _____years
How many packs per day do you or did you smoke? _____packs per day
Have you quit using tobacco and if so, when? _____when did you quit

Alcohol Use

Per Week, how many cans/bottles of beer_____, glasses of wine_____, and shots of hard liquor_____ do you consume?
Do you have a history of alcoholism ☐Yes ☐No
Do you attend or have you attended Alcoholics Anonymous? ☐Yes ☐No

Drug Use

Do you have a history of heroin, cocaine or amphetamine abuse, or addiction to other substances? ☐Yes ☐No

If Yes, which one(s) _____

Have you ever been in a detoxification program for drug abuse? ☐Yes ☐No

Do you attend or have you attended Narcotics Anonymous? ☐Yes ☐No

If you are clean and sober, how long have you been abstinent _____years

Does anyone in your family have a history of addiction to substances? ☐Yes ☐No
If Yes, What Relation(s) _____

PSYCHOSOCIAL HISTORY

Education:

Your highest educational level achieved:

- ☐ graduate or professional training (Doctorate degree)
- ☐ graduate or professional training (Master's degree)
- ☐ college graduate (Bachelor's degree)
- ☐ college graduate (Associate degree)
- ☐ partial college training
- ☐ high school graduate
- ☐ GED or trade-technical school graduate
- ☐ partial high school (10th grade through partial 12th)
- ☐ primary school (6th grade or less)

EMPLOYMENT

Current employment status (please check all that apply):

- ☐Employed full-time
- ☐Employed part-time
- ☐Temporarily disabled
- ☐Permanently disabled
- ☐Unemployed
- ☐Homemaker
- ☐Retired
- ☐Student
- ☐Unemployed because of pain

Your current or former occupation(s)**:**_____

SPINAL DIAGNOSTICS AND THERAPEUTICS INITIAL VISIT

I hereby authorize the release of the reports of my evaluations and treatments, including psychological, at the UCD Pain Treatment Center to my physicians and to the other relevant persons listed below:

Signature :_____

Date :_____

Printed Name :_____

Physicians/Providers/Attorney/Case Manager/Other	Address	Phone FAX
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