Integrated
Pain & Rehabilitation Center

Deborah Fisher, MD, PA
Shana Fakkel, MPAS, PA-C
Kami Dever, MPAS, PA-C

220 E Evergreen St | Sherman, TX 75090 | P:(903)957-0470 | F:(903)957-0469

Patient Information Form

Name_____Phone_____Date of Birth_____

Social Security #_____Work #_____Place of employment_____

Home address_____City_____Zip_____

Spouse's Name_____Wk Phone_____Place of employment_____

Nearest Relative not living with you_____Phone #_____

Nearest Friend not living with you_____Phone #_____

Whom may we contact in case of emergency? _____Phone # _____

Whom may we thank for referring you?_____

Who is responsible for the charges that may incur?_____

Insurance information

Primary Policy _____ID#_____Group#_____

Type of Insurance Plan: (HMO, PPO, POS)_____Referral needed?_____

Primary Policy Holder's Name _____Date of birth_____

Social Security#_____Place of Employment:_____

Secondary Policy _____ID#_____Group#_____

Type of Insurance Plan: (HMO, PPO, POS)_____Referral needed?_____

Primary Policy Holder's Name _____Date of birth_____

Social Security#_____Place of Employment:_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this and subsequent sheets and have completed the answers. I certify this information to be true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Patient's Signature or Parent (if minor) Date

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Patient History Questionnaire

Patient Name:_____ Date of Birth:_____

Date of visit:_____ Doctor who sent you_____

List all Doctors you see_____ _____ _____

Reason for your visit:_____

History of Present Illness (HPI):

1. Location:_____
2. Approximately what date did your pain start?_____
3. What caused the pain?_____
   Was your injury ☐ work related ☐MVA ☐ Other (please specify)
   Describe what happened _____
   _____
4. Have you had any of the following tests? Please specify.
   ☐ EMG _____ ☐ CT Myelogram _____
   ☐ CT Scan _____ ☐ Bone Scan _____
   ☐ MRI _____ ☐ Bone Density Scan _____
   ☐ Discogram _____
5. Have you had any of the following treatments? Please indicate a number that describes the pain relief that you received. No relief • 0 1 2 3 4 5 6 7 8 9 10 • Complete relief
   ☐ Joint injection___ ☐ Epidural injection ____ ☐ Trigger Point ___
   ☐ Facet Joint ___ ☐Narcotic pump implant ___ ☐ Botox injections___
   ☐Chiropractic Treatment___ ☐ Spinal cord stimulator implant ___
6. Are you involved in a lawsuit regarding your case? ☐ Yes ☐ No
7. Have you ever had psychiatric/psychological counseling? ☐ Yes ☐No
   Where?_____ When?_____

Past Medical History:

☐high blood pressure	☐emphysema	☐cancer_____
☐diabetes mellitus	☐osteoarthritis	☐thyroid problems
☐stroke	☐rheumatoid arthritis	☐depression
☐asthma	☐headaches	☐stomach problems
☐copd	☐heart disease	☐sexual difficulties
☐seizures	☐gout	☐hepatitis c
☐high cholesterol	☐HIV/AIDS	☐osteoporosis
☐fibromyalgia	☐reaction to anesthesia	☐other _____

Previous Medications Used: (please circle)
Demerol ♦ Dilaudid ♦ Codiene ♦ MS Contin ♦ Kadian ♦ Embeda ♦ Avinza ♦ Methadone ♦ Percocet
Percodan ♦ Talwin ♦ Nubain ♦ Hydrocodone ♦ Tylenol 3 or 4 ♦ Ultram ♦ Ultracet ♦ Lortab ♦ Vicoden
Oxycontin ♦ Oxycodone ♦ Opana ♦ Duragesic Patch ♦ Fentanyl Patch ♦ Actiq ♦ Fentora ♦ Nucynta
Elavil ♦ Lyrica ♦ Neurontin ♦ Cymbalta ♦ Xanax ♦ Valium ♦ Flexeril ♦ Soma ♦ Zoloft ♦ Trazadone

Have you had any problems with use or abuse with any prescription medications? ☐ Yes ☐ No

Previous Surgical History:
Please List all surgeries you have had and the date.

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Medical allergies:_____

Medications: Please list ALL medications you take, including over the counter, and dosing.

_____	_____
_____	_____
_____	_____
_____	_____

Family History:
Father ☐Living ☐Deceased Age:_____
If deceased, cause of death_____
Medical History:_____

Mother ☐Living ☐Deceased Age:_____
If deceased, cause of death_____
Medical History:_____

Siblings ☐Living ☐Deceased Age:_____
If deceased, cause of death_____
Medical History:_____

Are there any family members with a history of alcoholism? ☐Yes ☐No
If yes, who?_____

Are there any family members with a history of drug abuse? ☐Yes ☐No
If yes, who?_____

Social History:
Marital Status (please circle one)
Single Married Separated Divorced Widowed

Do you smoke? ☐Yes How much?_____ ☐No ☐Quit _____

Do you drink alcohol? ☐Yes ☐No
If yes how many drinks per month _____, per week _____, or per day _____?

Have you been through drug or alcohol rehab? ☐Yes ☐No

Have you ever overused pain medications? ☐Yes ☐No

Social History (continued)

Have you ever taken any of the following? ☐Yes ☐No
If yes, please circle which ones.
Marijuana ♦ Cocaine ♦ Heroin ♦ Speed ♦ Crystal Meth ♦ Amphetamines ♦ PCP ♦ Ecstasy ♦ Crack

Are you currently employed? ☐Yes ☐No Occupation_____

Medical equipment: please check all that apply
☐Wheelchair ☐Power Wheelchair ☐Walker ☐Cane ☐Commode

Review of Systems (ROS): Please check yes or no for all of the following problems that apply to you.

Constitutional		***Ears/Nose/Mouth/Throat***	
Good general health	☐Yes ☐No	Hearing loss or ringing	☐Yes ☐No
Recent weight change	☐Yes ☐No	Sinus problems	☐Yes ☐No
Night sweats, fevers	☐Yes ☐No	Nose bleeds	☐Yes ☐No
Fatigue	☐Yes ☐No	Sore throat/voice change	☐Yes ☐No
Musculoskeletal		***Respiratory***	
Muscle pain or cramps	☐Yes ☐No	Shortness of breath	☐Yes ☐No
Stiffness/swelling joints	☐Yes ☐No	Cough	☐Yes ☐No
Joint pain	☐Yes ☐No	Wheezing/asthma	☐Yes ☐No
Trouble walking	☐Yes ☐No	Coughing up blood	☐Yes ☐No
Neurological		***Eyes***	
Frequent headaches	☐Yes ☐No	Wears corrective lenses	☐Yes ☐No
Paralysis or tremors	☐Yes ☐No	Blurred/double vision	☐Yes ☐No
Convulsions/seizures	☐Yes ☐No	Eye disease/injury	☐Yes ☐No
Numbness/tingling	☐Yes ☐No	Glaucoma	☐Yes ☐No
Cardiovascular		***Psychiatric***	
Chest pain	☐Yes ☐No	Insomnia	☐Yes ☐No
Palpitations	☐Yes ☐No	Confusion/memory loss	☐Yes ☐No
Heart trouble	☐Yes ☐No	Depression	☐Yes ☐No
Swelling hands/feet	☐Yes ☐No	Suicidal/homicidal ideas	☐Yes ☐No
Endocrine		***Gastrointestinal***	
Excessive thirst/urination	☐Yes ☐No	Nausea/vomiting	☐Yes ☐No
Thyroid disease	☐Yes ☐No	Abdominal pain	☐Yes ☐No
Hormone problem	☐Yes ☐No	Bowel problems	☐Yes ☐No

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signed:_____Date:_____

Physician Statement: I have reviewed the questionnaire with the patient:

Signed:_____Date:_____

****

For office use only.
☐Reviewed objectives that will be used to determine treatment success, such as pain relief and improved physical function.
☐Other options reviewed: Alternate pain medications besides narcotics
Chiropractic Acupuncture PT Psychiatry referral Surgical referral
☐Reviewed: anticipated therapeutic results possibility for lack of pain relief informed consent
expectations for sustained pain relief and improved functioning plan for periodic review
risks of narcotics including addiction, dependence/impairment of judgment, and motor skills

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Patient Information Form
Assignment of Benefits

Patient:_____ SSN:_____

I hereby instruct and direct_____Insurance Company to pay by check made out and mailed to:

Deborah Fisher MD, PA
220 E Evergreen St
Sherman, TX 75090

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct the insurance company to make out the check to me and mail it as follows:

c/o Deborah Fisher MD, PA
220 E Evergreen St
Sherman, TX 75090

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHT AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. This payment will remain in effect until revoked by me in writing.

A photocopy of this Assignment shall be considered as effective and valid as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjustor, State or Federal entity, or attorney involved in this case. I acknowledge that my medical records may be transmitted by facsimile to other Healthcare Providers, Insurance Carriers, or Government entities, involved in my medical care.

_____ _____
Signature Date

Notice concerning complaints

Complaints about physicians, as well as other licensees & registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:

Texas State Board of Medical Examiners
333 Guadalupe, Tower 3, Suite 610
PO Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following Telephone number: 1-800-201-9353.

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Financial Policy

PRIVATE OR COMMERCIAL INSURANCE
Patients with medical insurance should remember that professional services are rendered and charged to the patient. You, as the patient, are responsible for fees arising from services proved. Your deductible amount or office copayment is to be paid at the time service is rendered per the contractual obligations between you and your carrier. If in the event your insurance company becomes insolvent, your account will not be held pending resolution of bankruptcy hearings. You will be held responsible for the bill.

WORKER'S COMPENSATION
We will be glad to file claims for you with your company's workers compensation provider. Correct information for billing must be supplied by you. If litigation is involved, the Office Manager must be kept informed of the status of your claim. If at some point the Worker's Compensation carrier determines your claim is not work related, you will be held responsible for the charges incurred.

MEDICARE/SECONDARY SUPPLEMENTS
We will file your Medicare and Medicare supplement for you. Medicare patients will need to pay their deductible or 20% of the allowable charges, unless they have a Medicare supplementary insurance.

THE UNINSURED PATIENT
We recognize that there are occasions when surgical care is needed by a patient who does not carry health insurance. In such circumstances, each case will be treated in a highly individualized manner. Arrangements must be made with the Financial Counselor prior to the service being rendered or, in case of an emergency on the first follow-up visit.

COLLECTION POLICY
An account is considered delinquent and eligible for legal action **after 60 days have passed** from the date of service. If payment is not received from an insurance company within 60 days, the patient is expected to either contact the insurance company and/or pay the balance in full. If your insurance carrier delays payment past 60 days, you will be billed for your account. Please remember, that you have a commitment with the insurance carrier, so you must work out any problems that arise regarding your benefit plan or eligibility. We will assist you as we can but you are ultimately responsible for any delays, omissions or referrals to pay by your carrier. The only exception is in the event that the physician has a contract with your carrier, and payments are adjusted per our contractual obligations. If an account has to be referred for collection, the patient is responsible for all fees and costs, which are incurred.

TREATMENT OF MINORS
In the event a minor comes to this office for treatment, the legal guardian must be available to approve treatment of the child. If the child warrants surgery, the legal guardian must sign the consent forms. The individual who brings the child in for treatment will be responsible for paying all copayments at the time that services are rendered, regardless of their status as guarantor.

SIGNATURE_____ **DATE**_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

TO ANY PHYSICAN, HOSPITAL, CLINIC, OR THEIR REPRESENTATIVE
You are hereby authorized and requested to deliver and furnish to:

Deborah Fisher MD, PA

Fax To: (903)957-0469
220 E Evergreen St.
Sherman, TX 75090
(903)957-0470

All records, written report, x-rays, EMG/NCV reports, and any other data or information pertaining to the condition and treatment of:

_____ _____
Patient Name Patient Date of Birth

Please forward the following date of service:

_____All dates of service

From_____ To_____

Specific request:_____

Referring Dr. _____

Phone:_____Fax:_____

X_____
Authorized Signature of Patient or Guardian **Date**

X_____
Witness

A PHOTOCOPY OF THE AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

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Acknowledgement of Review of Notice of Privacy Practices for the office of Deborah Fisher MD, PA

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if I request it.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Please list any person you will allow this office to disclose information to. Please indicate what type of information may be disclosed (ie: billing, test results, general health information):

Name Information Permissable to be Disclosed

1)_____

2)_____

3)_____

4)_____

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Agreement Form for the Continued Use of Opioid and Analgesic Medications

I understand that the prescription of opioid and other analgesic medications are for the management of chronic intractable pain that has not responded to other treatments. The risks, side effects, and benefits have been explained to me, and I agree to the following conditions of treatment.
I agree that our treatment goal is to use the analgesic dose that is both safe and effective in relieving my pain and one that allows me to be functional.
I will take my medications as prescribed and will not change the dosage or schedule without the doctors approval.
One doctor. All opioid medications for treatment of pain will be prescribed by one doctor.
One pharmacy. I will designate and use only one pharmacy for my analgesic prescriptions.
If I have another condition develop that requires the prescription of a controlled substance, I will notify the doctor immediately.
I understand that lost or stolen prescriptions will not be replaced, and I will not request early refills. Replacement of stolen medications will only be considered upon receipt of a Police Report.
Prescription refills. Please ask your pharmacist to fax through to us the request for medication refills 24 hours in advance (allow extra time for weekends and holidays). Prescriptions that are triplicates should be requested 24 hours in advance and picked up after 4:00pm.

a. **Shall be made during regular office hours** Monday through Friday, and picked up in person. **Refills will not be made at night, on holidays, or weekends.**
b. **Refills shall not be made if** I "run out early" or "lose a prescription" or spill or misplace my medication. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen I will report this to my local police department and **obtain a stolen item report**. Replacement prescriptions will be given at the discretion of the physician.
c. **Shall not be made as an emergency** such as on Friday afternoon because the patient suddenly realized he/she will "run out tomorrow".

I agree to abstain from all illegal and recreational drugs including alcohol. I agree to random urine drug screens as my doctor deems necessary.

Patient Signature:_____ Date:_____

Patient printed name:_____

Name & telephone of Pharmacy:

_____

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INFORMED CONSENT & OPIOID WAIVER

Name: _____ Date: _____

I have agreed to use opioids (morphine-like drugs) as part of my treatment for chronic pain. I understand that these drugs are very useful, but have a potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician is prescribing such medication to help manage my pain, I agree to the following conditions. I am aware that failure to abide by any of these conditions will be considered a breach of our agreement and at the sole discretion of my physician, may result in the termination of our physician/patient relationship.

The following issues pertain to the treatment of chronic pain with opioids (ie morphine-like drugs):

2. **DRUG DEPENDENCE**: There are two types of dependence.
   Physical dependence is common to many drugs including steroids, blood pressure medications, anti-anxiety medications, anti-seizure medications, as well as opioids. Physical dependence poses no problem to the patient as long as the patient avoids abrupt discontinuation of the drug. The medication can be safely discontinued after a period of tapering off (see point #9).
   Physical dependence or addition is a rare occurrence in patients who have been diagnosed with an organic disease causing chronic pain. Addiction is recognized when the patient abuses the drub to obtain mental numbness or euphoria, when the patient shows a drug craving behavior or "doctor shopping", when the drug is quickly escalated without correlation to pain relief and/or when the patient shows a manipulative attitude toward the physician in order to obtain the drug. If the patient exhibits such behavior the drug will be tapered; such a patient is not a candidate for the opioid trial and he/she may be discharged.
3. **TOLERANCE**: Tolerance to pain relief is a much rarer phenomenon than was previously believed. It is defined as a need for a higher opioid dose to maintain the same effect. Usually, tolerance to sedation, euphoria, nausea, and vomiting will occur more commonly that tolerance to pain relief. There are several types of opioids. If the patient develops tolerance to one opioid medication, he/she can be switched to a different opioid. Tolerance can also be managed by adding a second, different drug to the opioid management. If tolerance to opioids becomes unmanageable, the opioid will be discontinued.
4. **SIDE EFFECTS**: The most common side effects are nausea and vomiting (similar to motion sickness), drowsiness and constipation. The less common side effects would occur at the beginning of the treatment and often would spontaneously disappear within a few days. At the beginning of the opioid treatment, other medications may be given to counteract the obove side effects. If, at the beginning of the medication of the medication the patient experiences severe sedation, it is imperative for the patient to hold the next medication dose and contact his/her physican.
5. **DRIVING**: If the patient develops drowsiness, sedation, dizziness, he/she may not drive a motor vehicle or operate machinery that can jeopardize his/her or other people's safety.
6. **SINGLE PHYSICIAN**: A single physician will prescribe the opioids**. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician at Deborah Fisher MD, PA.** The same physican will be managing the possible side effects during the first few weeks of the opioid treatment. The physician will be the only one to decide when and how the patient is to increase the opioid daily dose. If the physician decides to discontinue the use of opioids, she will follow the patient through the tapering off period.
7. **DOSE**: The end point of the opioid trial will be significant degree of pain relief, unmanageable side effects or lack of benefit because of tolerance. The opioid dose will be slowly titrated up over several days. Because of possible side effects, the opioid dose titration might be delayed. The physican will

make use of either a slow release or long-acting opioid medication, which will be given one to tree times a day.

8. **PERSONAL USE**: The patient is informed that the opioid medication is strictly for personal relief. The opioid should never be distributed to others. Once the maintenance opioid dose has been achieved, the patient will be given a monthly supply and no exceptions will be made. If the patient needs to pick up a prescription the patient is to call the clinic trenty-four hours ahead. He/she is to pick up the prescription after 4:00 p.m. During the time that his/her dose is being adjusted, he/she will be expected to return to the clinic no less frequently than one time per month. After he/she has been placed on a stable dose, he/she will return to the clinic whenever instructed by his physician. If this is not possible he/she will request care to be transferred back to his/her primary care physician.
   The patient is responsible for opioid prescriptions. The patient understands that refill prescriptions:
   a. Can only be written for a one-month supply and will be filled at the same pharmacy.
   b. **Shall be made during regular office hours** Monday through Friday, and picked up in person. **Refills will not be made at night, on holidays, or weekends.**
   c. **Refills shall not be made if** I "run out early" or "lose a prescription" or spill or misplace my medication. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen I will report this to my local police department and **obtain a stolen item report**. Replacement presciptions will be given at the discretion of the physician.
   d. **Shall not be made as an emergency** such as on Friday afternoon because the patient suddenly realized he/she will "run out tomorrow". The patient will call twenty-four hours in ahead to schedule pick up for his prescriptions.
9. **COMMUNICATION**: At the beginning of the opioid trial, the patient, however, is responsible for contacting the physician if at anytime excessive drowsiness or other major side effects develop (see point #3). After office hours, the patient should call 911.
9. **WITHDRAWAL SYNDROME**: The patient is informed that he/she should not stop taking the opioid medication abruptly. If this happens, withdrawal symptoms usually occur 24 to 48 hours after the last dose. The patient may begin to experience yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh" abdominal cramps, and diarrhea. The withdrawal syndrome is self-limited and is not life threatening. It may last a few days. In order to avoid the withdrawal symptoms the patient is informed that he/she is to contact the office twenty-four hours prior to needing a new prescription.
10. **DRUG INTERACTION**: The patient is informed that he/she may not take other drugs such as tranquilizers, sedatives, or antihistamines without first consulting with his/her physican. The patient may not use alcohol. The combination use of the above drugs, alcohol, and opioids may produce profound sedation, respiratory depression and blood pressure drop.

WARNING: During the opioid trial, the upward titration of the drug is conducted under the close supervision of the physician. It is imperative for the patient to follow the physician's directions and not to increase the opioid dose on his/her own. Drug over-dose can cause sever sedation and respiratory depression and MAY EVEN CAUSE DEATH.

I, _____ have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids (ie morphine-like drugs) have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy.

Patient Signature:_____ Date:_____

Physician Signature:_____

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Name:_____ Date:_____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their plan. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0=Never 1=Seldom 2=Sometimes 3=Often 4=Very Often

1. How often do you have mood swings? 0 1 2 3 4
2. How often have you felt a need for higher doses of medication to treat your pain? 0 1 2 3 4
3. How often have you felt impatient with your doctors? 0 1 2 3 4
4. How often have you felt that things are just too overwhelming that you can't handle them? 0 1 2 3 4
5. How often is there tension at home? 0 1 2 3 4
6. How often have you counted pain pills to see how many are remaining? 0 1 2 3 4
7. How often have you been concerned that people will judge you for taking pain medications? 0 1 2 3 4
8. How often do you feel bored? 0 1 2 3 4
9. How often have you taken more pain medication than you are supposed to? 0 1 2 3 4
10. How often have you worried about being left alone? 0 1 2 3 4
11. How often have you felt a craving for medication? 0 1 2 3 4
12. How often have others expressed concern over your use of medication? 0 1 2 3 4
13. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4
14. How often have others told you that you had a bad temper? 0 1 2 3 4
15. How often have you felt consumed by the need to get pain medication? 0 1 2 3 4
16. How often have you run out of pain medication early? 0 1 2 3 4
17. How often have others kept you from getting what you deserve? 0 1 2 3 4

Please continue on the next page

0=Never 1=Seldom 2=Sometimes 3=Often 4=Very Often

18. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4
19. How often have you attended an AA or NA meeting?	0 1 2 3 4
20. How often have you been in an argument that was so out of control someone got hurt?	0 1 2 3 4
21. How often have you been sexually abused?	0 1 2 3 4
22. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
23. How often have you had to borrow pain medications from your family or friends?	0 1 2 3 4
24. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

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Illegal Substance Agreement

I _____ am not currently taking any illegal substances including Marijuana. I understand that taking these substances are illegal and if they are found in my drug screen, I will be dismissed from this practice.

Provider_____ Patient_____

Date_____

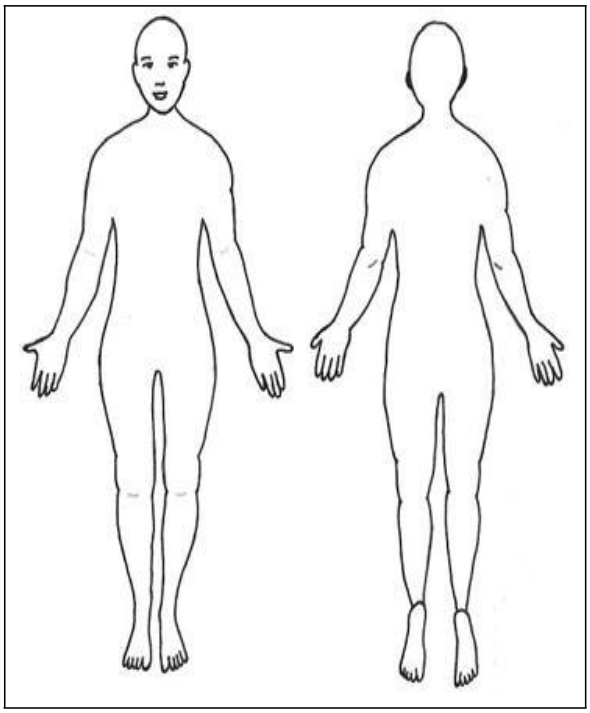
☐ AMD
☐ UA
☐Notes_____

Pain Assessment Sheet

Name:_____ Date:_____ _____

1. Location of Pain:_____
2. Is there any possibility that you are pregnant? ☐ yes ☐ no
3. Circle the words that describe your pain:

aching	sharp	penetrating
throbbing	tender	nagging
shooting	burning	numb
stabbing	exhausting	miserable



4. Is your pain? ☐occasional ☐intermittent ☐constant

5. Pain rating – Please use the scale below to rate your pain

No pain	Mild	Moderate	Distressing	Excruciating
0	1 2 3	4 5 6	7 8 9	10

Pain intensity at this time _____
Pain intensity at its least over the last month_____
Pain intensity at its worst over the last month_____

6. Please indicate which activities increase your pain

☐sitting	☐standing	☐lying down
☐climbing	☐bending over	☐walking
☐squatting	☐reaching overhead	☐other_____
☐kneeling	☐driving	

7. Please indicate what decreased your pain

☐medications	☐rest	☐heat/ice
☐exercise	☐ other _____	

8. Please use scale below to rate how your pain interferes with the following activities.

0 1 2 3 4 5 6 7 8 9 10

Does not interfere. Completely interferes.

_____general activities	_____mood	_____walking
_____normal work	_____relations with others	_____sleep
_____enjoyment of life	_____sexual activity	_____appetite

9. Do you have any of the following symptoms associated with your pain?

_____nausea	_____change in appetite	_____decreased physical activity
_____vomiting	_____depression	_____anger/frustration
_____problems with concentration	_____suicidal/homicidal ideas	

10. List what medications you are taking.

_____ _____ _____

_____ _____ _____

11. Side effects of medications.
☐constipation ☐sedation ☐swelling ☐weight gain

12. Has the pain affected your ability to work? ☐ yes ☐no

13. Did you take your medication according to instructions? ☐yes ☐no

14. Did you have to call the office between appointments? ☐yes ☐no
Why?_____

15. Since my last visit I am…. ☐same ☐worse ☐better

16. When is your pain the worst? ☐morning ☐noon ☐night

REVIEWED BY:_____