AMERICAN PAIN CONSORTIUM

Center For Pain | Integrated Pain Solutions | Spine Care Specialists

Together With American Pain Consortium

NEW PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____ Home: _____ Work: _____

SSN ____ - ____ - _____ Sex: ☐ F ☐ M DOB: _____/_____/_____

Email address: _____ Preferred Language: _____

Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Partner ☐ Widow/Widower ☐ Separated

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White ☐ Native Hawaiian/Pacific Islander

☐ Other: _____ ☐ Decline to Specify

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Specify

Patient Employer: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____

OTHER INFORMATION

Primary Care Physician: _____ Phone #: _____ Fax #: _____

Primary Pharmacy Name: _____ Phone #: _____

PAIN HISTORY

When did your pain begin: _____

Describe how your pain began: _____

_____

_____

PEG Scale Assessing Pain Intensity and Interference (Pain, Enjoyment, General Activity)

1. What number best describes your pain on average in the past week?

No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | *Pain as bad as you can imagine*

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

Does not | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | *Completely interferes*

3. What number best describes how, during the past week, pain has interfered with your general activity?

Does not | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | *Completely interferes*

OVER

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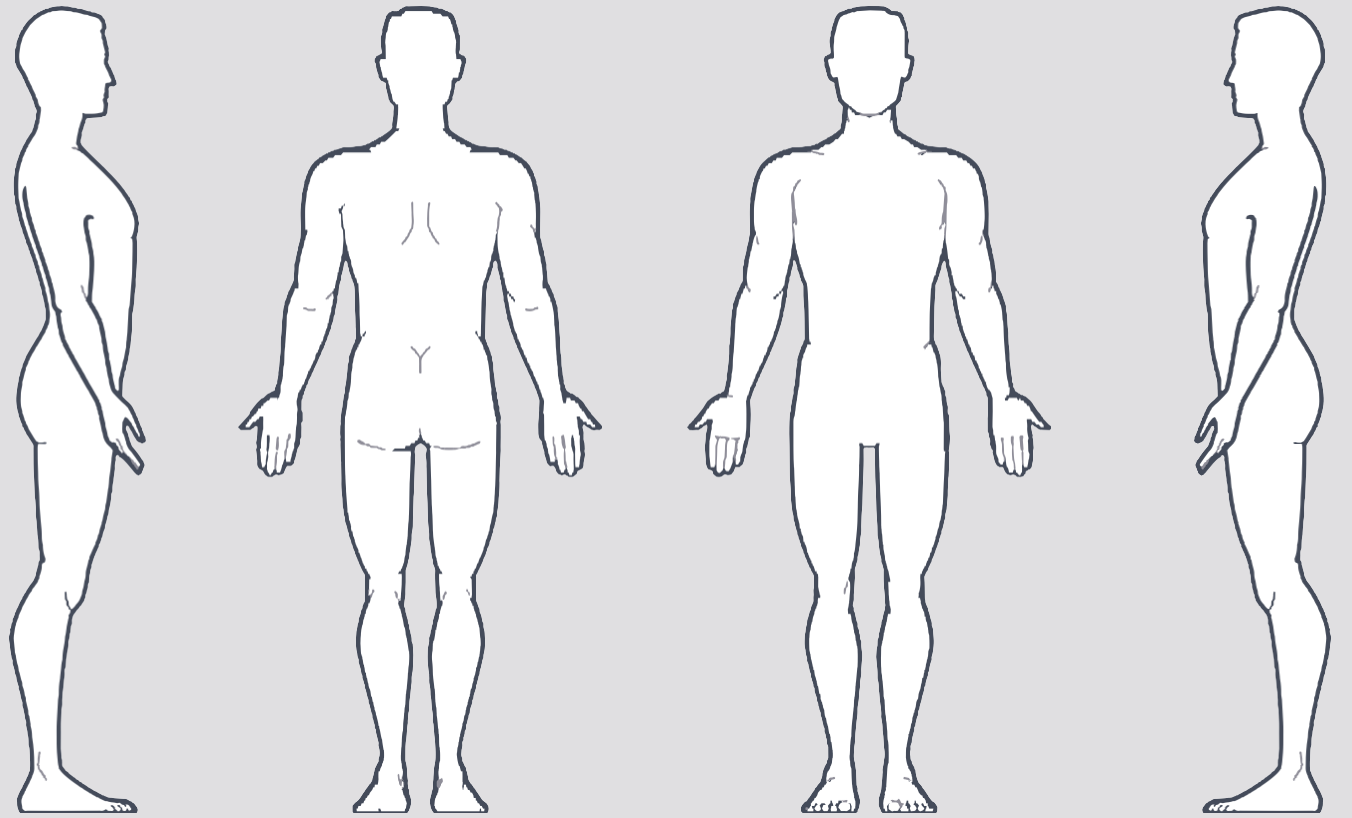
Patient Name:_____ DOB:_____

Where is your pain located? Please mark all areas of pain. Circle most severe area:



Right Side | Back | Front | Left Side

Does your pain radiate?

☐ Yes ☐ No

If pain radiates, check if you have:

☐ Numbness ☐ Tingling

If pain radiates, check where the pain radiates:

Arm: ☐ R ☐ L ☐ Both

Down to: ☐ Shoulder ☐ Elbow ☐ Wrist/Hand

Leg: ☐ R ☐ L ☐ Both

Down to: ☐ Hip ☐ Knee ☐ Ankle/Foot

Describe your pain (check):

☐ A Spasm	☐ Dull	☐ Pressure	☐ Stabbing
☐ Aching	☐ Fire	☐ Sharp	☐ Stinging
☐ Burning	☐ Hot	☐ Shock-like	☐ Tenderness
☐ Cold	☐ Numb	☐ Shooting	☐ Throbbing
☐ Cramping	☐ Pinching	☐ Squeezing	☐ Tingling

Describe the timing of your pain (check):

☐ Continuous	☐ Worse in the Morning
☐ Intermittent	☐ Worse in the Afternoon
☐ Nonspecific	☐ Worse in the Evening/Night
☐ Pulsatile	

What makes pain better? (check):

☐ Nothing	☐ Position Change
☐ Activity	☐ Rest
☐ Acupuncture	☐ Sitting
☐ Chiropractic Care	☐ Standing
☐ Heat	☐ Steroid Injections
☐ Ice	☐ Surgery
☐ Lying Down	☐ TENS
☐ Massage	☐ Walking
☐ Prescription Medication	☐ Use of Pain Pump
☐ Over-the-Counter Medication	☐ Use of Spinal Cord Stimulator
☐ Physical Therapy	

What makes pain worse? (check):

☐ Activity	☐ Lying Down	☐ Touch
☐ Bending	☐ Movement	☐ Turning Over
☐ Cold	☐ Nothing	☐ Walking
☐ Everything	☐ Physical Therapy	☐ Weather
☐ Lifting	☐ Position Change	☐ Working
☐ Looking Around	☐ Sitting	☐ Weight Bearing
☐ Looking Down	☐ Standing	
☐ Looking Up	☐ Standing-up	

Please rate your pain *WITH medication*:

0	1	2	3	4	5	6	7	8	9	10

Please rate your pain *WITHOUT medication*:

0	1	2	3	4	5	6	7	8	9	10

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Patient Name: _____ DOB: _____

Please check mark any medication you have tried to treat your pain			Reason for stopping (check best option):	
✓	Name of Drug	If not currently taking, last dose?	Not helpful	Side effect/ allergy
	NSAID/Acetaminophen			
	Motrin (Ibuprofen)			
	Naprosyn/Naproxen (Aleve)			
	Lodine			
	Relafen			
	Indocin			
	Mobic (Meloxicam)			
	Tylenol (Acetaminophen)			
	Diclofenac			
	Anti-Anxiety			
	Valium (Diazepam)			
	Xanax (Alprazolam)			
	Lorazepam			
	Lexapro (Escitalopram)			
	Cymbalta (Duloxetine)			
	Tricylic Antidepressant			
	Elavil (Amitriptyline)			
	Pamelor (Nortriptyline)			
	Doxepin			
	Tofranil			
	Deyrel			
	Anti-Convulsant			
	Neurontin (Gabapentin)			
	Lyrica (Pregabalin)			
	Topamax (Topriamate)			
	Depakote			
	Tegretol			
	Dilantin			
	Lamictal			
	Gralise (Gabapentin ER)			
	Constipation			
	Relistor			
	Amitiza			
	Symproic			
	Movantik			
	Miralax/Milk of Magnesia			
	Metamucil/Benefiber			
	Colace			
	Dulcolax/Senokot			
	Muscle Relaxant			
	Skelaxin			
	Norflex			
	Soma (Carisoprodol)			
	Flexeril (Cyclobenzaprine)			
	Zanflex (Tizanidine)			
	Baclofen			
	Sleep			
	Ambien (Zolpidem)			
	Trazadone			
	Belsomra			
	Silenor (Doxepin)			
	Lunesta (Eszopiclone)			

Please check mark any medication you have tried to treat your pain			Reason for stopping (check best option):	
✓	Name of Drug	If not currently taking, last dose?	Not helpful	Side effect/ allergy
	Opioid			
	Ultram (Tramadol)			
	Ultram ER (Tramadol ER)			
	Percocet (Oxycodone)			
	Oxycontin (Oxycodone ER)			
	Xtampza (Oxycodone ER)			
	Vicodin/Lortab/Norco (Hydrocodone)			
	Hysingla (Hydrocodone ER)			
	Zohydro (Hydrocondone ER)			
	Dilaudid (Hydromorphone)			
	Exalgo (Hydromorphone ER)			
	Duragesic Patch (Fentanyl Patch)			
	Morphine			
	MS Contin (Morphine ER)			
	Methadone			
	Nucynta			
	Butrans Patch (Buprenorphine)			
	Belbuca (Buprenorphine)			
	Suboxone			
	Levorphanol			
	Migraine			
	Imitrex/Sumatriptin			
	Amerge			
	Maxalt			
	Relpax			
	Zomig			
	Botox			
	Ajovy			
	Aimovig			
	Emagality			
	Nurtec			
	Other			
	Pennaid Cream			
	Ketamine Gel			
	Lidoderm Patch (Lidocaine Patch)			
	Medical Marijuana			
	Flector Patch			
	Lidoderm Gel (Lidocaine Gel)			
	Voltaren Gel (Diclofenac Gel)			

OVER

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Patient Name:_____ DOB:_____

Please check any procedures you have tried to treat your pain

✓	Name of Treatment	Date of Last Visit?	Number of Visits
	Acupuncture		
	Biofeedback		
	Chiropractic Care		
	Massage Therapy		
	Physical Therapy		
	Psychotherapy		
	TENS		
	Botox		
	Lumbar Epidural Injection		
	Cervical Epidural Injection		

✓	Name of Treatment	Date of Last Visit?	Number of Visits
	Lumbar Medial Branch Block/Facet Injection		
	Cervical Medial Branch Block/Facet Injection		
	Lumbar Radiofrequency Ablation		
	Cervical Radiofrequency Ablation		
	Sacroiliac (SI) Joint Injection		
	Joint Injection with Steroid		
	Pain Pump Trial		
	Spinal Cord Stimulator Trial		

CURRENT MEDICATIONS

Please list ALL medication you are currently taking (prescription, over-the-counter, herbal supplements, vitamins). Include dose and frequency.
Attach a separate sheet if needed.

_____

_____

_____

_____

_____

_____

_____

Side effects from pain medication (check):

- ☐ None
- ☐ Anxiety
- ☐ Constipation
- ☐ Depression
- ☐ Diarrhea
- ☐ Sweating
- ☐ Dizziness
- ☐ Nausea
- ☐ Hangover Feeling
- ☐ Headache
- ☐ Insomnia
- ☐ Lethargy
- ☐ Night Sweats
- ☐ Palpitations
- ☐ Vomiting
- ☐ Dry Mouth

Severity of side effects (check):

- ☐ Mild
- ☐ Moderate
- ☐ Severe

ALLERGIES

Please list ALL allergies and their reactions. Include any medication, latex, dye, and food allergies. Attach a separate sheet if needed.

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

Please check if you have any of these conditions now or have been diagnosed with them in the past:

Constitutional:

- ☐ Unexplained weight loss of more than 10lbs
- ☐ Fever in the last few days

Cardiovascular:

- ☐ High blood pressure
- ☐ Cholesterol
- ☐ Chest pain/pressure
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Cardiac surgery
- ☐ Irregular heartbeat

Pulmonary:

- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Asthma
- ☐ Cough

Liver/Genitourinary:

- ☐ Ulcers
- ☐ Hepatitis
- ☐ Pancreatitis
- ☐ Urinary tract infections
- ☐ Bladder problems
- ☐ Kidney problems
- ☐ Kidney stones
- ☐ Other liver problems

Endocrine:

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Hormone issues
  Explain:_____

Gastrointestinal:

- ☐ Acid reflux
- ☐ Stomach ulcers

Nervous System:

- ☐ Seizures
- ☐ Stroke
- ☐ Head injury
- ☐ Paralysis
- ☐ Peripheral neuropathy

Musculoskeletal:

- ☐ Neck/back problems
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Fibromyalgia

Psychiatric:

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Panic disorder
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ Other: _____

Other:

- ☐ Cancer (Type:_____)
- ☐ HIV/AIDS
- ☐ STD (Type:_____)
- ☐ Tuberculosis
- ☐ Claustrophobia
- ☐ COVID-19

Patient Name: _____ DOB: _____

SURGICAL HISTORY

Please list ALL surgeries. Attach a separate sheet if needed.

Year: _____ Surgery: _____

Year: _____ Surgery: _____

Year: _____ Surgery: _____

Year: _____ Surgery: _____

Any problems with Anesthesia (nausea/vomiting/difficulty waking up/other): _____

HOSPITALIZATION

Please list ALL hospitalizations. Include any not related to pain as well (pneumonia, heart issues, etc). Attach a separate sheet if needed.

Year: _____ Reason: _____

Year: _____ Reason: _____

Year: _____ Reason: _____

FAMILY HISTORY

For each of the following family members, list their year of birth, age at death if applicable, and if they had a history of any of the following conditions: Diabetes, Hypertension, Heart Disease, Cancer, Kidney Problems, Lung Problems, Depression, Allergies, and Arthritis:

Mother: _____

Father: _____

IMAGING

Please list any imaging (X-ray, MRI, CT, EMG, etc.) done in the last 5 years for your pain. Attach a separate sheet if needed. If time permits, please contact the facility and have the report faxed to the number on the cover letter.

Date of exam: _____ Test: _____ Facility: _____

Date of exam: _____ Test: _____ Facility: _____

Date of exam: _____ Test: _____ Facility: _____

Date of exam: _____ Test: _____ Facility: _____

OVER

AMERICAN PAIN CONSORTIUM

Patient Name: _____ DOB: _____

SOCIAL HISTORY

Smoking:

Do you currently smoke cigarettes?
☐ Yes ☐ No

If yes, do you smoke cigarettes every day?
☐ Yes ☐ No

How many cigarettes per day?

_____

If you use other tobacco products, what kind?

_____

If you are a former smoker, when did you quit?

_____

Alcohol:

Have you had a drink containing alcohol in the past year?
☐ Yes ☐ No

If yes, how often?
☐ Monthly or less ☐ 2-4x per month
☐ 2-3x per week ☐ 4-7x per week

If yes, how many drinks at one time?
☐ 1-2 ☐ 3-4 ☐ 5-6
☐ 7-9 ☐ 10 or more

If yes, how often did you binge drink (>5 drinks at once)?
☐ 0 ☐ < Monthly ☐ Monthly
☐ Weekly ☐ Daily/Almost Daily

Do you drink to decrease your pain?
☐ Yes ☐ No

Other Drugs:

Have you ever used illegal substances?
☐ Yes ☐ No

If yes, what kind?

_____

☐ Marijuana ☐ Heroin ☐ Cocaine
☐ Ecstasy ☐ LSD ☐ Meth

Last time?

_____

Have you ever used prescription medication not prescribed to you? ☐ Yes ☐ No

If yes, what medication?

_____

Last time?

_____

Do you currently have a Medical Marijuana Card?
☐ Yes ☐ No

Sleep:

On average, how many hours of sleep do you get at night?

_____

Quality of sleep:
☐ Difficulty falling asleep ☐ Difficulty staying asleep

Is this due to pain?
☐ Yes ☐ No

In the past year, my level of sleep has:
☐ Increased ☐ Stayed the same ☐ Decreased

WORK HISTORY

Employment Status - please check:

☐ Employed full-time
☐ Retired
☐ Homemaker
☐ Unemployed for another reason
☐ On permanent disability/long-term disability
☐ Employed part-time
☐ Retired early due to pain
☐ Unemployed due to pain
☐ In school/training
☐ On temporary disability/short-term disability

If still working, current position:

_____

That type of work is:
☐ Sedentary (sit most of day, minimal lifting, < 10lbs)
☐ Light (stand most of day, lift up to 20lbs)
☐ Medium (stand most of day, lift 20-50lbs)
☐ Heavy (stand most of day, lift 50-100lbs)

If not working due to pain, who took you off work:
☐ Self
☐ Physician: _____

Do you need our office to continue completing your off work paperwork?
☐ Yes ☐ No

Do you think you will be able to return to some sort of employment if not retired?
☐ Yes ☐ No

On a scale of 0 - 10, how close are you to returning to work (10 = back to full time, 0 = not even close to working any type of job)?

0	1	2	3	4	5	6	7	8	9	10

AMERICAN PAIN CONSORTIUM

Patient Name:_____ DOB:_____

OSWESTRY LOW BACK PAIN DISABILITY

Instructions: This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just check the one box that indicates the statement which most clearly describes your problem.

SECTION 1 – PAIN INTENSITY	**SECTION 6 – STANDING**
I have no pain at the moment.(0)	I can stand as long as I want without extra pain.(0)
The pain is very mild at the moment.(1)	I can stand as long as I want but it gives me extra pain.(1)
The pain is moderate at the moment.(2)	Pain prevents me from standing for more than one hour.(2)
The pain is fairly severe at the moment.(3)	Pain prevents me from standing for more than 30 minutes.(3)
The pain is very severe at the moment.(4)	Pain prevents me from standing for more than 10 minutes.(4)
The pain is the worst imaginable at the moment.(5)	Pain prevents me from standing at all.(5)
SECTION 2 – PERSONAL CARE (washing, dressing, etc.)	**SECTION 7 – SLEEPING**
I can look after myself normally without causing extra pain.(0)	My sleep is never disturbed by pain.(0)
I can look after myself normally but it causes extra pain.(1)	My sleep is occasionally disturbed by pain.(1)
It is painful to look after myself and I am slow and careful.(2)	Because of pain, I have less than 6 hours of sleep.(2)
I need some help but manage most of my personal care. (3)	Because of pain, I have less than 4 hours of sleep.(3)
I need help every day in most aspects of self-care.(4)	Because of pain, I have less than 2 hours of sleep.(4)
I do not get dressed; I wash with difficulty and stay in bed.(5)	Pain prevents me from sleeping at all.(5)
SECTION 3 – LIFTING	**SECTION 8 – SEX LIFE (if applicable)**
I can lift heavy weights without extra pain.(0)	My sex life is normal and causes no extra pain.(0)
I can lift heavy weights but it gives extra pain.(1)	My sex life is normal but causes some extra pain.(1)
Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed, e.g. on a table.(2)	My sex life is nearly normal but is very painful.(2)
Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)	My sex life is severely restricted by pain.(3)
I can lift very light weights.(4)	My sex life is nearly absent because of pain.(4)
I cannot lift or carry anything at all.(5)	Pain prevents any sex life at all.(5)
SECTION 4 – WALKING	**SECTION 9 – SOCIAL LIFE**
Pain does not prevent me walking any distance.(0)	My social life is normal and gives me no extra pain.(0)
Pain prevents me from walking more than 2 kilometers/1 mile.(1)	My social life is normal but increases the degree of pain.(1)
Pain prevents me from walking more than 1 kilometer/1/2 mile.(2)	Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports. (2)
Pain prevents me from walking more than 500 meters/100 yards. (3)	Pain has restricted my social life. I do not go out as often.(3)
I can only walk using a stick or crutches.(4)	Pain has restricted my social life to my home.(4)
I am in bed most of the time.(5)	I have no social life because of pain.(5)
SECTION 5 – SITTING	**SECTION 10 – TRAVELING**
I can sit in any chair as long as I like.(0)	I can travel anywhere without pain.(0)
I can only sit in my favorite chair as long as I like.(1)	I can travel anywhere but it gives me extra pain.(1)
Pain prevents me from sitting more than one hour.(2)	Pain is bad but I manage journeys over two hours.(2)
Pain prevents me from sitting more than 30 minutes.(3)	Pain restricts me to journeys of less than 1 hour.(3)
Pain prevents me from sitting more than 10 minutes.(4)	Pain restricts me to short necessary journeys under 30 min.(4)
Pain prevents me from sitting at all.(5)	Pain prevents me from traveling except to receive treatment.(5)

AMERICAN PAIN CONSORTIUM

Patient Name:_____ DOB: _____

PATIENT HEALTH QUESTIONNAIRE - 9

Over the **last two weeks**, how often have you been bothered by any of the following problems?
Please answer the questions below using the following scale:

0 = Not At All | 1 = Several Days | 2 = More than half the days | 3 = Nearly Every Day

1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

FOR OFFICE CODING 0 + + +

=Total Score:

AMERICAN PAIN CONSORTIUM

Patient Name:_____ DOB: _____

SOAPP® VERSION 1.0-14Q

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. 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 do you smoke a cigarette within an hour after you wake up?	0	1	2	3	4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0	1	2	3	4
4. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
5. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
6. How often have you attended an AA or NA meeting?	0	1	2	3	4
7. How often have you taken medication other than the way that it was prescribed?	0	1	2	3	4
8. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4
9. How often have your medications been lost or stolen?	0	1	2	3	4
10. How often have others expressed concern over your use of medication?	0	1	2	3	4
11. How often have you felt a craving for medication?	0	1	2	3	4
12. How often have you been asked to give a urine screen for substance abuse?	0	1	2	3	4
13. How often have you used illegal drugs (for example: marijuana, cocaine, etc.) in the past 5 years?	0	1	2	3	4
14. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4

For Staff Use: Total Score: _____