RIVLIN MEDICAL GROUP

CHRONIC PAIN MANAGEMENT

www.rivlinmedicalgroup.com

601-89 Queensway Ave. West | Mississauga, ON L5B 2V2 | F: 905.281.9143 | T: 905.281.9898

Patient Information

Today's date: _____

Your name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

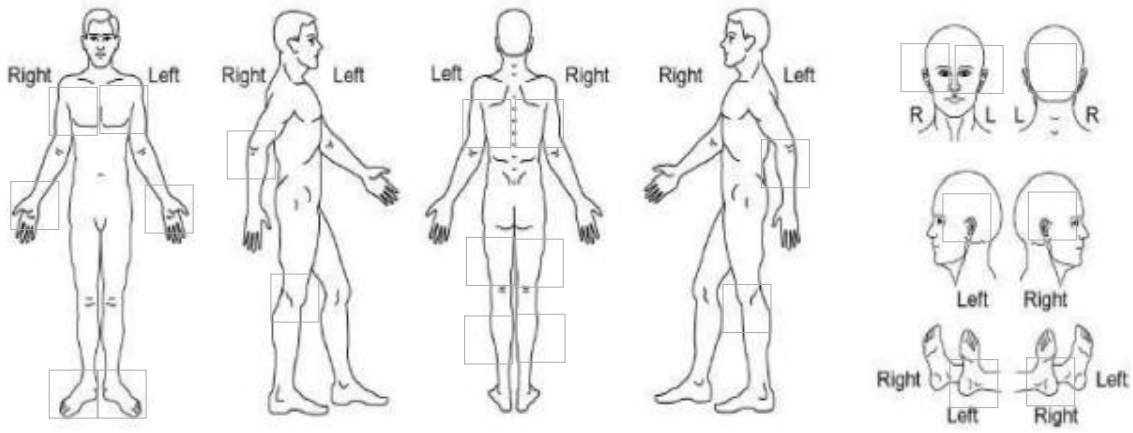
Pain History

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so where?_____

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description

Check all of the following that describe your pain:

☐ Dull/Aching	☐ Cramping	☐ Squeezing
☐ Hot/Burning	☐ Numbness	☐ Tingling/Pins and Needles
☐ Shooting	☐ Spasm	☐ Tightness
☐ Stabbing/Sharp	☐ Throbbing	

When is your pain at its worst?

☐ Mornings	☐ Evenings	☐ Always the same
☐Daytime	☐ Middle of the night	

How often does the pain occur?

☐ Constant	☐ Changes in severity but always present	☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

Mark the effect each of the following have on your pain level

	Increases	Decreases	No Change
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking upward	☐	☐	☐
Looking downward	☐	☐	☐
Rising from seated position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Bending Backward	☐	☐	☐

What other factors worsen or affect your pain which is not mentioned above?

_____

_____

Associated Symptoms

	No	Yes	Comments
Numbness/Tingling	☐	☐	Where_____
Weakness in the arm/leg	☐	☐	_____
Balance Problems	☐	☐	_____
Bladder Incontinence	☐	☐	_____
Bowel Incontinence	☐	☐	_____
Joint Swelling/Stiffness	☐	☐	_____
Fevers/chills	☐	☐	_____

Please mark all of the following treatments you have used for pain relief

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
TENS Unit	☐	☐	☐

Other: _____

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar
☐ Joint Injection – Joint(s) _____
☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar
☐ MILD (Minimally Invasive Lumbar Decompression) - _____
☐ Nerve Blocks – Area/Nerve(s) -_____
☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar
☐ Spinal Cord Stimulator – Trial Only/Permanent Implant _____
☐ Trigger Point Injections – Where_____
☐ Vertebroplasty/Kyphoplasty – Level(s) _____
☐ Other_____

Which of these procedures listed above have helped with your pain?

_____

Diagnostic Tests and Imaging

☐MRI of the: _____ Date: _____
☐X-Ray of the: _____ Date: _____
☐CT Scan of the: _____ Date: _____
☐EMG/NCV study of the: _____ Date: _____
☐Other Diagnostic Testing: _____ Date: _____
☐ I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist	☐ Neurosurgeon	☐ Psychiatrist/Psychologist
☐ Chiropractor	☐ Orthopedic Surgeon	☐ Rheumatologist
☐ Internist	☐ Physical Therapist	☐ Neurologist

☐ Other :_____

Past Medical History

Please list the names of other Pain Physicians you have seen in the past?_____
_____

Mark the following conditions/diseases you have been treated for in the past:

General Medical
- ☐Cancer - Type _____
- ☐Diabetes - Type _____

Cardiovascular/Hematologic
- ☐Anemia
- ☐Heart Attack
- ☐Coronary Artery Disease
- ☐High Blood Pressure
- ☐Peripheral Vascular Disease
- ☐Stroke/TIA
- ☐Heart Valve Disorders

Gastrointestinal
- ☐GERD (Acid Reflux)
- ☐Gastrointestinal Bleeding
- ☐Stomach Ulcers
- ☐Constipation

Urological
- ☐Chronic Kidney Disease
- ☐Kidney Stones
- ☐Urinary Incontinence
- ☐Dialysis

Neuropsychological
- ☐Multiple Sclerosis
- ☐Peripheral Neuropathy
- ☐Seizures
- ☐Depression
- ☐Anxiety
- ☐Schizophrenia
- ☐Bipolar Disorder

Head/Ears/Eyes/Nose/Throat
- ☐Headaches
- ☐Migraines
- ☐Head Injury
- ☐Hyperthyroidism
- ☐ Hypothyroidism
- ☐Glaucoma

Respiratory
- ☐Asthma
- ☐Bronchitis/Pneumonia
- ☐Emphysema/COPD

Musculoskeletal/Rheumatologic
- ☐Bursitis
- ☐Carpal Tunnel Syndrome
- ☐Fibromyalgia
- ☐Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

Other Diagnosed Conditions
- ☐_____
- ☐_____
- ☐_____
- ☐_____
- ☐ _____
- ☐_____

Past Surgical History

Please list any surgical procedures you have done in the past including date:

1) _____ Date? _____
2) _____ Date? _____
3) _____ Date? _____
4) _____ Date? _____
5) _____ Date? _____

☐I have **NEVER** had any surgical procedures

Current Medications

Are you currently taking any blood thinners or anti coagulants? ☐YES ☐NO

If YES, which ones? ☐Aspirin ☐Coumadin ☐Lovenox ☐Other: _____

	Medication	Dose	Frequency
1)	_____		
2)	_____		
3)	_____		
4)	_____		
5)	_____		
6)	_____		
7)	_____		
8)	_____		
9)	_____		
10)	_____		

Please list all past pain medications that you have been on at any point for your current pain complaints?

	Medication	Dose	Frequency
1)	_____		
2)	_____		
3)	_____		
4)	_____		
5)	_____		

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No
If so, please list all medications you are allergic to:

	Medication	Allergic Reaction
1)	_____	
2)	_____	
3)	_____	
4)	_____	
5)	_____	

Family History

Mark all appropriate diagnoses and your first degree relatives:

☐Arthritis
☐Cancer
☐Diabetes
☐Headaches/Migraines
☐High Blood Pressure
☐Kidney Problems
☐Liver Problems
☐Osteoporosis
☐Rheumatoid arthritis
☐Seizures
☐ Stroke
☐Other Medical Problems: _____
☐ I have no significant family medical history

Social History

Occupation: _____ When was the last time you worked? _____
Who is in your current household? _____
Are there any stairs in your current home? _____If so how many? _____
☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed
Are you currently under worker's compensation? ☐ No ☐ Yes
Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Alcohol Use:
☐ Social Use ☐History of Alcoholism ☐Current Alcoholism ☐Never ☐ Daily use of alcohol

Tobacco Use:
☐ Current user ☐ Former user ☐ Never used
☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

Illegal Drug Use:
☐ Denies any illegal drug use ☐ Currently uses illegal drugs
☐ Formerly used illegal drugs (not currently using)
Have **y**ou ever abused narcotic or prescription medication?

Psychology Intake Form

Many people experience emotional difficulties as a result of their chronic pain. Please indicate which of the following common occurrences you experience.

	YES	NO
• disturbing nightmares		
• frequent sadness or crying		
• sleeping difficulties, including trouble falling asleep or staying asleep		
• increased fear while being in or around cars		
• changes in appetite		
• increased stress in your relationships with others		
• feeling tense, worried or nervous		
• difficulties with concentration and getting things done		
• low energy, including less interest in previously enjoyed activities		
• memory problems		
• irritability, frustration or outbursts of anger		
• difficulty coping with the pain		
• efforts to avoid situations that are associated with ……		
• flashbacks or intrusive thoughts of ……..		

Signature of Patient, Parent or Guardian: _____

DN4 – QUESTIONNAIRE

To estimate the probability of neuropathic pain, please answer yes or no for each item of the following four questions

To be completed by the PATIENT

QUESTION 1: Does the pain have one or more of the following characteristics?

	YES	NO
Burning	☐	☐
Painful cold	☐	☐
Electric shocks	☐	☐

QUESTION 2: Is the pain associated with one or more of the following symptoms in the same area?

	Yes	No
Tingling	☐	☐
Pins and needles	☐	☐
Numbness	☐	☐
Itching	☐	☐

To be completed by PHYSICIAN

QUESTION 3: Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?

	YES	NO
Hypoesthesia to touch	☐	☐
Hypoesthesia to pinprick	☐	☐

QUESTION 4: In the painful area, can the pain be caused or increased by:

	YES	NO
Brushing?	☐	☐

☐ Male ☐ Female

Patient's score: /10

Do you have a <u>family history</u> (e.g. parents, siblings, children etc.) of substance abuse involving any of the following?

Yes = 1 Point
No = 0 Points

- Alcohol ❑ Yes ❑ No
- Prescription drugs ❑ Yes ❑ No
- Drugs (e.g. cocaine, ecstasy, marijuana etc.) ❑ Yes ❑ No

Do you have any history yourself of substance abuse, or have you been diagnosed with a substance abuse disorder involving any of the following?

- Alcohol ❑ Yes ❑ No
- Prescription drugs ❑ Yes ❑ No
- Drugs (e.g. cocaine, ecstasy, marijuana etc.) ❑ Yes ❑ No

Your age: ❑ 16-45 ❑ over 45

Do you have, or have you ever been diagnosed with any of the following:

- attention-deficit/hyperactivity disorder
- obsessive compulsive disorder
- bipolar disorder
- schizophrenia

❑ Yes ❑ No

Do you have, or have you ever been diagnosed with depression?

❑ Yes ❑ No

We understand that this may be a sensitive matter, and your answer will be treated in the strictest confidence within your family circle of care, however it is important in your assessment. Do you have a history of preadolescent abuse?

❑ None ❑ Physical ❑ Emotional ❑ Sexual