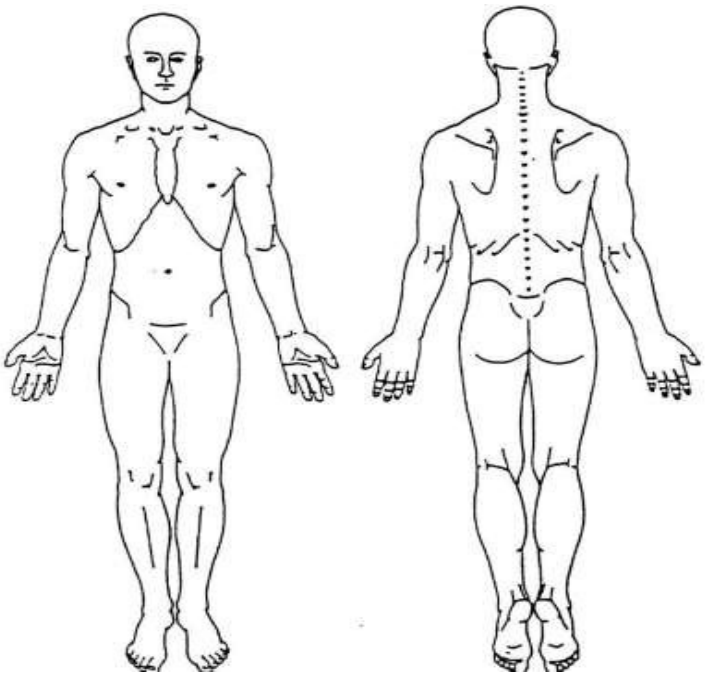
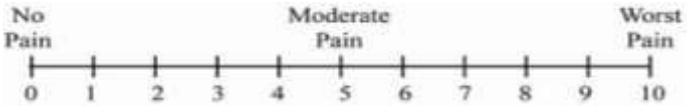
Pain Management Center, Inc

152 Treemonte Drive
Orange City, Florida 32763

Use the diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms: **"N"**umbness **"P"**ins and Needles **"A"**ching **"S"**tabbing **"B"**urning





What is your current pain level **right now**? _____

Where is your worst area of pain located? _____

_____

List any additional areas of pain: _____

_____

What word **best describes** the frequency of your pain**?**
❑ Constant ❑ Intermittent

When is your pain at its **worst?** ❑ Mornings

❑ During the day ❑ Evenings ❑ Middle of the night

Check all that describe your pain today:

❑ Aching	❑ Numb	❑ Spasming	❑ Throbbing
❑ Cramping	❑ Shock-like	❑ Squeezing	❑ Tingling/Pins and Needles
❑ Dull	❑ Shooting	❑ Stabbing/Sharp	❑ Tiring/Exhausting
❑ Hot/Burning			

Since Your Last Visit:

Has your pain? ❑ Increased ❑ Decreased ❑ Stayed the Same

Any new medication side effects? ❑ No ❑ Yes Please List: _____

Any new medications? ❑ No ❑ Yes Please List: _____

Any new allergies? ❑ No ❑ Yes Please List: _____

Any new imaging studies? ❑ No ❑ Yes Please List: _____

Did you have a procedure? ❑ No ❑ Yes **If yes**, how much pain relief did you obtain?_____%. Were there any problems? ❑ No ❑ Yes If yes, please explain: _____

_____

Current Opioid Therapy, if applicable (for example, Percocet, oxycontin, duragesic patch):

What percent relief do your opioids (narcotics) provide? (Please give number) _____ ?

Do you have any side effects from your opioids? (Circle those that apply) no side effects, constipation, itching, nausea, dry mouth, erectile problems, menstrual problems, vomiting, dizziness, sleepiness, lightheadedness, appetite changes, problems urinating, tooth decay.

Are you more functional from using opioids? (Circle) **NO YES** If yes, how? _____

_____

Are your opioids kept in a secure place? (Circle) **NO YES** Where? _____

Do you feel that your mood has improved from opioid therapy? (Circle) **NO YES** If yes, how? _____

Has the quality of your life improved? (Circle) **NO YES** If yes, how? _____

_____

Mark the following symptoms that you currently suffer from:

Constitutional:
- ❑ Chills
- ❑ Difficulty Sleeping
- ❑ Fatigue
- ❑ Fevers
- ❑ Night Sweats

Eyes:
- ❑ Recent Visual Changes

Ears/Nose/Throat/Neck:
- ❑ Difficulty Hearing
- ❑ Earaches
- ❑ Hay fever/Allergies
- ❑ Nosebleeds
- ❑ Recurrent Sore Throats
- ❑ Ringing in the Ears
- ❑ Sinus Problems

Cardiovascular/Respiratory:
- ❑ Chest Pain
- ❑ Cough
- ❑ Difficulty Breathing
- ❑ Fainting
- ❑ High Blood Pressure
- ❑ Swelling in the Feet

Gastrointestinal:
- ❑ Constipation
- ❑ Dark and Tarry Stools
- ❑ Diarrhea
- ❑ Nausea/Vomiting

Genitourinary/Nephrology:
- ❑ Blood in Urine
- ❑ Involuntary Urination
- ❑ Loss of Bowel Control
- ❑ Painful Urination
- ❑ Pelvic Pressure

Musculoskeletal:
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Neck Pain

Neurological:
- ❑ Dizziness
- ❑ Headaches
- ❑ Instability When Walking
- ❑ Numbness/Tingling
- ❑ Weakness

Psychiatric:
- ❑ Anxiety/Stress
- ❑ Depressed Mood
- ❑ Suicidal Thoughts
- ❑ Suicidal Planning

Patient Signature _____ Date _____