DR.CATHY ZHANG
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Patient Information

Today's date: ______________________________

Your name: ________________________________ Date of Birth: ________________ Age: _________

Referring Physician: ________________________ Primary Care Physician: ______________________________

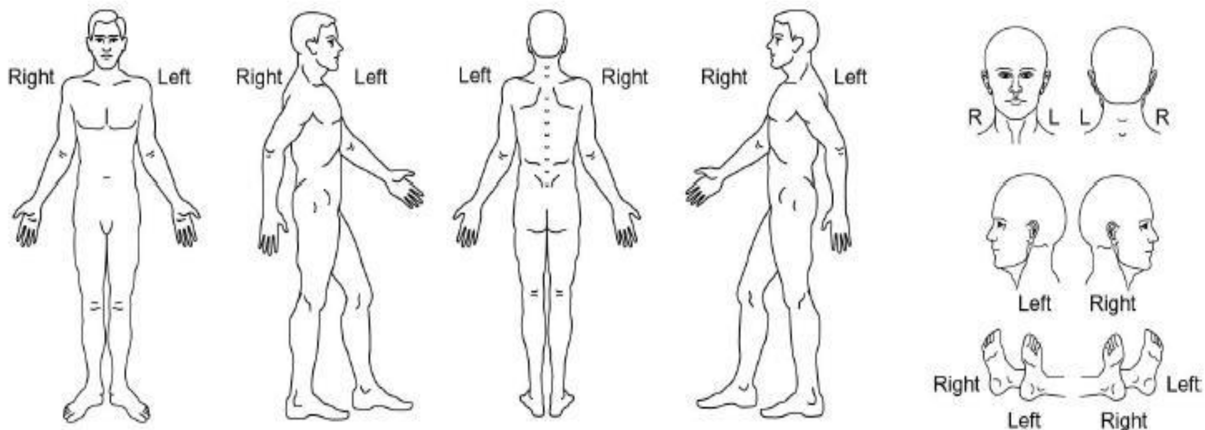
Pain History

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

Describe the character of your pain (eg: dull, stabbing, throbbing, etc):

____

What time of day is your pain at its worst? ____

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__________

What other factors worsen or affect your pain?

____

What other factors relieve your pain?

____

Are there any associated symptoms? (eg: numbness/tingling/weakness/incontinence, etc)

____

What are the goals you wish to achieve with Pain Management? ______________________________

____

Diagnostic Tests and Imaging

Mark all of the following tests that you have had related to your current pain complaints:

☐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

Please mark all of the following treatments you have had 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	☐	☐	☐

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

☐ 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? ____________________

____

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

____

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

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

Cancer/Oncology

☐ Cancer – Type ________________
☐ Cancer – Type________________
☐ Cancer – Type________________

Cardiovascular/Hematologic

☐ Anemia
☐ Heart Attack
☐ Coronary Artery Disease
☐ High Blood Pressure
☐ Peripheral Vascular Disease
☐ Stoke/TIA
☐ Heart Valve Disorders
☐ Presence of stent/pacemaker/ defibrillator

Gastrointestinal

☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Stomach Ulcers
☐ IBS/Crohns Disease

Urological

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

Neurological

☐ Multiple Sclerosis
☐ Peripheral Neuropathy
☐ Seizures
☐ Balance Disorder
☐ Head Injury
☐ Headaches
☐ Migraines

ENT

☐ Glaucoma
☐ Vertigo
☐ Hearing Problems
☐ Nosebleeds

Respiratory

☐ Asthma
☐ Bronchitis/Pneumonia
☐ Emphysema/COPD

Musculoskeletal/Rheumatologic

☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Chronic Joint Pains

Psychological

☐ Depression
☐ Anxiety
☐ Schizophrenia
☐ Bipolar Disorder
☐ ADD/ADHD
☐ PTSD

Endocrinology

☐ Diabetes – Type______________
☐ Hyperthyroidism
☐ Hypothyroidism

Other Diagnosed Conditions

☐ ______________________________
☐ ______________________________
☐ ______________________________
☐ ______________________________

Past Surgical History

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

1) ______________________________ Date? __________

2) ______________________________ Date? __________

3) ______________________________ Date? __________

4) ______________________________ Date? __________

5) ______________________________ Date? __________

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

Family History

Mark all appropriate diagnoses as they pertain to your parents and siblings:

☐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 ☐ Daily use of alcohol ☐Never ☐ History of alcoholism ☐ Current alcoholism

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

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

Current Medications

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

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other ________________

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

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

Only if any of your medications cause constipation, please answer these questions. If not, skip this section.

On average, how often do you have a bowel movement? (Please check one)

☐ **More than 3 times per day**
☐ **2 to 3 times per day**
☐ **Once per day**
☐ **2 to 3 times per week**
☐ **Less than once per week**

Think back to when you started pain medicine. Did your bowel habits change? If so how?

____

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to

Medication Name	Allergic Reaction
1) ____________________	____________________
2) ____________________	____________________
3) ____________________	____________________
4) ____________________	____________________
5) ____________________	____________________

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional: ☐Fevers ☐Chills ☐Sweats ☐Weakness ☐Fatigue ☐Decreased Activity ☐Malaise ☐Unexplained weight gain ☐Unexplained weight loss ☐Low sex drive ☐Difficulty sleeping

Eyes: ☐Blurriness ☐Double vision ☐Visual disturbance ☐Pain

Ears/Nose/Throat/Neck: ☐Hearing problems ☐Ear pain ☐Sinus problems ☐Sore throat ☐Nosebleeds

Respiratory: ☐Shortness of breath ☐Cough ☐Sputum production ☐Wheezing

Cardiovascular: ☐Chest pain ☐Palpitations ☐Swelling in feet ☐Shortness of breath during sleep ☐Bleeding disorder ☐Blood clots ☐Fainting

Gastrointestinal: ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Heartburn ☐Abdominal pain

Genitourinary/Nephrology: ☐Painful urination ☐Blood in urine ☐Change in urine stream ☐Unusual discharge ☐Flank pain ☐Urinary incontinence

Musculoskeletal: ☐Back pain ☐Neck pain ☐Joint pain ☐Muscle pain ☐Muscle cramp ☐ Muscle spasm ☐Gait disturbances ☐Joint stiffness ☐Joint swelling ☐Trauma

Integumentary: ☐Rash ☐Itching ☐Lesions ☐Bruising

Neurological: ☐Abnormal balance ☐Confusion ☐Numbness ☐Tingling ☐Dizziness ☐Headaches ☐Loss of coordination ☐Memory loss ☐Seizures ☐Tinnitus ☐Tremors ☐Vertigo

Psychiatric: ☐Feeling anxious ☐Depressed mood ☐Suicidal thoughts ☐Hallucinations ☐Stress problems ☐Suicidal planning ☐Thoughts of harming others