Arroyo Vista Advanced Pain Specialists, Inc.

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Tel.: (805) 222-4549 Fax: (805) 529-4549

Today's Date: _____

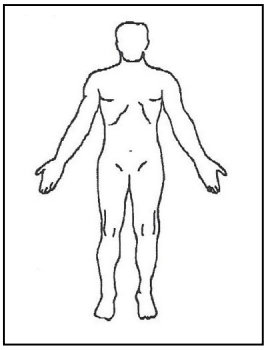
_____ Age _____ Sex: F □ M □
Your Name: Last, First MI

Referring MD: _____ Primary Care MD: _____

About Your Pain (Diagnosis)
What is the main problem for which you are seeking treatment?
_____

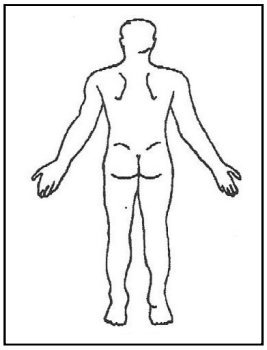
1. Pain Description:
   _____
   _____
   _____

Right



Front

Left



Back

Right

New Symptoms:
_____
_____
_____

Please mark the location(s) of your pain on the diagrams above with an "X." If whole areas are painful, please shade in the painful area.

2. Onset of Pain and Duration:
_____
_____

3. Timing of Pain:
   □ Constantly (100% of the time) □ Frequently (75% of the time) □ Intermittently (50% of the time) □ Occasionally (25% of the time)

4. Pain Quality:
   □ burning □ sharp □ cutting □ throbbing
   □ cramping □ numbness □ dull, aching □ pressure
   □ pins and needles □ shooting □ electric-like □ other _____

5. Rate your pain intensity by circling one number that best describes your pain right now:
   1 2 3 4 5 6 7 8 9 10
   No Pain Worst Pain Imaginable

6. Rate your pain intensity by circling one number that best describes your pain on average over the past week:
   1 2 3 4 5 6 7 8 9 10
   No Pain Worst Pain Imaginable

7. What is your percentage overall improvement since your last appointment at Arroyo Vista Advanced Pain Specialists (or prior clinic): _____%

8. In the past week, how much relief have your current pain treatments or medications provided? Please circle the percentage that best describes how much:

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

9. Since your last pain clinic visit activity level and ability to perform tasks has:
   Increased □ Unchanged □ Decreased □

10. Are you currently smoking or using tobacco products? Yes □ No □

11. Review of Systems:

Please check any of the following signs or symptoms that you are currently experiencing.	Yes		Office Use Only
Fever or chills?	□		
Unplanned weight loss?	□		
Double or blurred vision?	□		
Hearing loss?	□		
Difficulty swallowing?	□		
Bleeding gums?	□		
Low platelet count?	□		
Heat intolerance?	□		
Cold intolerance?	□		
Thyroid problems?	□		
Skin rash?	□		
Shortness of breath?	□		
Wheezing?	□		
Palpitations (awareness of fast heart)?	□		
Chest pain?	□		
Constipation?	□		
Abdominal pain?	□		
Nausea?	□		
Vomiting?	□		
Diarrhea?	□		
Sexual dysfunction?	□		
Urinary retention or difficulty urinating?	□		
Back pain?	□		
Neck pain?	□		
Joint pain (knee, elbow, hip, etc.)	□		
Muscle pain?	□		
Loss of consciousness or blackouts?	□		
Memory loss?	□		
Muscle weakness?	□		
Seizures?	□		
Trouble walking?	□		
Dizziness?	□		
Drowsiness?	□		
Excessive fatigue?	□		
Difficulty falling or remaining asleep?	□		
Loss of interest in hobbies or other activities?	□		
Difficulty concentrating?	□		
Feelings of guilt?	□		
Feeling depressed?	□		

12. Any new or different allergies to drugs, supplements, and/or foods, or any new or different allergy reactions or symptoms? _____

13. Prior injections or procedures: Yes □ No □
    Name of procedure performed on your last visit _____ None □
    If yes, did you notice any relief? Yes □ No □
    If yes, what percent relief did you notice? _____ %. For how long? _____
    Did you have any side effects from your last procedure? Yes □ No □
    If yes, what side effect(s)? _____