

Arroyo Vista Advanced Pain Specialists, Inc.

865 Patriot Drive, Suite 201A

Moorpark, CA 93021-3405

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

Today's Date: _____

Your Name: Last, First MI

Age _____

Sex: F M

Referring MD: _____

Primary Care MD: _____

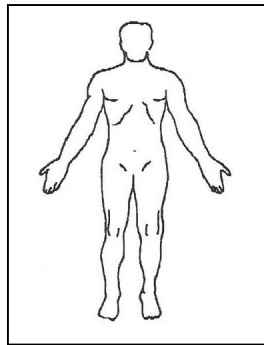
About Your Pain (Diagnosis)

What is the main problem for which you are seeking treatment?

1. Pain Description:

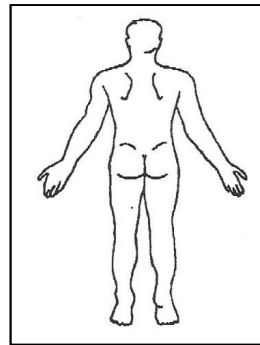
Right

New Symptoms:



Front

Left



Back

Right

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?	<input type="checkbox"/>		
Unplanned weight loss?	<input type="checkbox"/>		
Double or blurred vision?	<input type="checkbox"/>		
Hearing loss?	<input type="checkbox"/>		
Difficulty swallowing?	<input type="checkbox"/>		
Bleeding gums?	<input type="checkbox"/>		
Low platelet count?	<input type="checkbox"/>		
Heat intolerance?	<input type="checkbox"/>		
Cold intolerance?	<input type="checkbox"/>		
Thyroid problems?	<input type="checkbox"/>		
Skin rash?	<input type="checkbox"/>		
Shortness of breath?	<input type="checkbox"/>		
Wheezing?	<input type="checkbox"/>		
Palpitations (awareness of fast heart)?	<input type="checkbox"/>		
Chest pain?	<input type="checkbox"/>		
Constipation?	<input type="checkbox"/>		
Abdominal pain?	<input type="checkbox"/>		
Nausea?	<input type="checkbox"/>		
Vomiting?	<input type="checkbox"/>		
Diarrhea?	<input type="checkbox"/>		
Sexual dysfunction?	<input type="checkbox"/>		
Urinary retention or difficulty urinating?	<input type="checkbox"/>		
Back pain?	<input type="checkbox"/>		
Neck pain?	<input type="checkbox"/>		
Joint pain (knee, elbow, hip, etc.)	<input type="checkbox"/>		
Muscle pain?	<input type="checkbox"/>		
Loss of consciousness or blackouts?	<input type="checkbox"/>		
Memory loss?	<input type="checkbox"/>		
Muscle weakness?	<input type="checkbox"/>		
Seizures?	<input type="checkbox"/>		
Trouble walking?	<input type="checkbox"/>		
Dizziness?	<input type="checkbox"/>		
Drowsiness?	<input type="checkbox"/>		
Excessive fatigue?	<input type="checkbox"/>		
Difficulty falling or remaining asleep?	<input type="checkbox"/>		
Loss of interest in hobbies or other activities?	<input type="checkbox"/>		
Difficulty concentrating?	<input type="checkbox"/>		
Feelings of guilt?	<input type="checkbox"/>		
Feeling depressed?	<input type="checkbox"/>		

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)? _____