PAIN MANAGEMENT PHYSICIANS
OF SOUTH FLORIDA

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INITIAL CONSULTATION FORM

Date:____________

Please read these sheets carefully and answer all questions to the best of your ability. This will assist us in better treating your pain. Thank you for your time and cooperation.

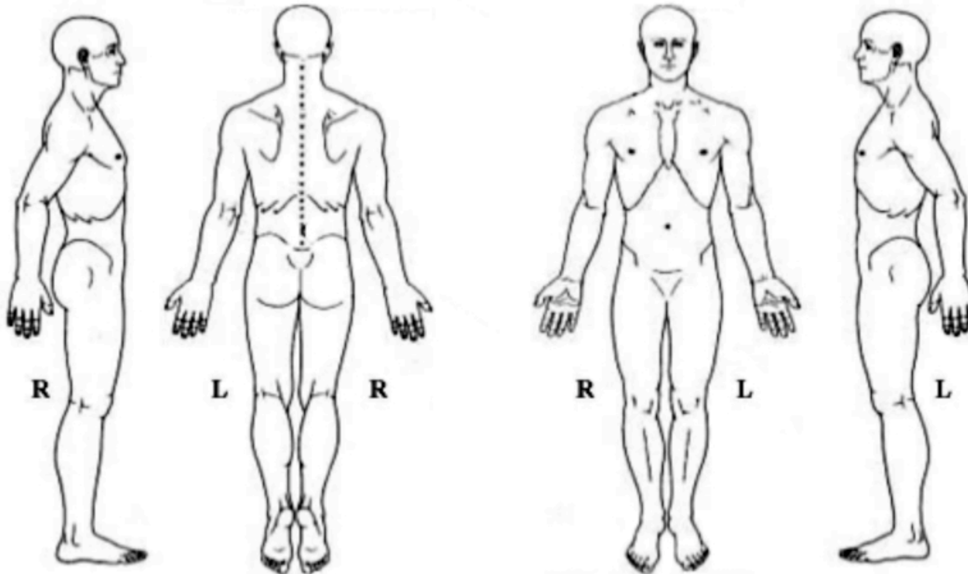
Name:

____
LAST FIRST

Age: ________________ Height: _____________ Weight: ____________

Referring Physician(s): ____
Other Physicians seen for this problem: _______________________________
Allergies or adverse reactions to MEDICATIONS (pill or injection): ___________
____
Other allergies: ____
HOW LONG HAVE YOU HAD THIS PAIN? ___________________________
____

Please shade in the areas on the diagrams where your pain is located.



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Please circle the appropriate words that best describe your pain.

ACHING	DULL	SHOOTING	CONSTANT
BURNING	TIGHT	TINGLING	RADIATING
CRAMPING	BRIEF	COLDNESS	SHARP
SORENESS	STABBING	NUMBING	

Please circle your answer.
Yes/No Do you have any bowel/bladder problems?
Yes/No Any recent weight loss?
Yes/No Was this a work related injury?
Yes/No Was this a motor vehicle accident related injury?
Assistive device: _____ None _____Cane _____ Walker _____ Wheelchair _____

Is the pain ____ constant or ____it comes and goes? (Check one)

Over time has the pain been getting better, staying the same or getting worse? (Circle)

Do the following factors make your pain worse:
Yes/No Standing
Yes/No Walking
Yes/No Prolonged walking
Yes/No Bending over
Yes/No Lifting or picking up heavy objects
Yes/No Straining
Yes/No Coughing
Yes/No Walking stairs
Yes/No Lying down
Yes/No Rainy weather
Yes/No Getting out of bed
Yes/No Getting out of car
Yes/No Anything else: ____
____

Do the following factors make your pain better:
Yes/No/Didn't try Lying down
Yes/No/Didn't try Ice
Yes/No/Didn't try Heat, Hot shower, Moist Heat
Yes/No/Didn't try Physical Therapy
Yes/No/Didn't try Massage
Yes/No/Didn't try Injections ____
____

Yes/No/Didn't try Nsaids (Motrin, Celebrex Advil,) ________________________
Yes/No/Didn't try Pain Meds (Codeine, Darvocet, Vicodin, Percocet) __________
Yes/No/Didn't try **Anything else**____
____

Have you ever tried the following medications for treating your pain:
Yes/No/Didn't try Muscle Relaxant (Flexeril, Skelaxin, Robaxin, Soma) _________
Yes/No/Didn't try Anticonvulsants (Neurontin, Lyrica, Tegretol,) ______________
Yes/No/Didn't try Antidepressants (Elavil, Cymbalta) _________________________
Yes/No Have you ever tried: ___Accupuncture ___ Chiropractor ___ TENS Unit

How many hours do you sleep? _______
Yes/No Does the pain wake you up?
Yes/No Do you take anything for sleep? If so, what? ________________________

Have you ever had any of the following studies done?
Yes/No MRI When: ________________ Report included: ☐
Yes/No X-ray When: ________________ Report included: ☐
Yes/No CT When: ________________ Report included: ☐
Yes/No EMG/Nerve Conduction Study
When: ________________ Report included: ☐

Results: ____
____

Past Medical/Surgical History:
Have you ever had treatment or are you presently receiving treatment for the following:
Yes/No Hypertension
Yes/No Heart Attack
Yes/No Angina
Yes/No Asthma
Yes/No Emphysema
Yes/No Liver problems
Yes/No Kidney problems
Yes/No Thyroid problems
Yes/No Diabetes
Yes/No Stroke/CVA/TIA
Yes/No Stomach ulcers
Yes/No Bruise easily
Yes/No Problems with bleeding
Yes/No Seizures
Yes/No Significant weight loss

What surgeries have you had in the past? ____________________________________
____
____

Patient or family history of problems with anesthesia ________________________
____

Current Medications: ____
____
____
____

Social History:

Yes/No Do you work now? If yes, where _________________ # hrs/day ______
Yes/No Are you retired?
Yes/No Are you on disability?
Yes/No Are you married? If yes, how long? _____
How many children do you have? _____ Do they live close by? _____
Yes/No Do you smoke? ______ If yes, how many packs/day? _____
Yes/No Do you drink? ______ If yes, how may drinks/week? _____

What do you do to keep busy, for fun? ____
____
Goals if the pain could be reduced? ____
____

Family History:

☐ Non-contributory for the patient's pain condition
☐ Other: ____

Review of Symptoms:

☐ Non-contributory for the patient's pain condition
☐ Other: ____
Temp ______ Pulse _______Resp _______ BP __________

The above information I have given is complete and accurate to the best of my knowledge:

Patient Signature: ________________________________ Date: ____________

R.N. Assisting: __________________________________ Date: ____________

I have reviewed the above information with the nurse and patient.

Physician Signature: _____________________________ Date: ____________