IPMASC.com

INTERVENTIONAL PAIN MANAGEMENT associates

IPMA

Initial Visit Questionnaire and Assessment

FOR OFFICE USE ONLY

Date: _____ Time: _____

B/P _____ Pulse _____ Respirations _____ O2 Sat _____ Ht _____ Wt _____

Females (age 13-50): LMP: _____ Hysterectomy/Tubal/Contraception Type_____Breastfeeding? ☐Yes ☐ No

Wt. loss greater than 10 lbs. in one month? ☐ No ☐ Yes **Recent infection:** ☐ No ☐ Yes, explain: _____

Coumadin/Plavix/Pletal/Lovenox/Heparin/Ticlid/Effient (circle) Date last dose taken: _____Dose: _____

Fall Risk? ☐ No ☐ Yes, explain: (cane, weakness, history of falls) _____

Person Providing Information: ☐Patient ☐ Other: _____ **Driver present?** ☐ No ☐ Yes

Learning/Communication Barriers? ☐ No ☐ Yes, explain: _____

Nurse Assessment: _____

_____

_____

Admitting Nurse: _____**Date**_____**Time**_____

Treatment Plan and Disposition

☐ Prescriptions written: _____

☐ Procedure Planned: _____

☐ Physical Therapy: _____

☐ Referral: _____

☐ Additional Teaching Material Given _____

☐ Imaging Ordered: _____

☐ Other Treatment Plan: _____

Discharge Nurse: _____ **Date:** _____ **Time:** _____

Patient Label

In your own words, why were you referred to our facility? _____

_____

Known drug allergies: □ No □ Yes If yes, please list them here_____

Are you allergic to: □Latex □ IV Dye □Betadine □ Xray contrast

PAIN ASSESSMENT

Date Pain was first noticed: ____/____/____(month/date/year)

Injury related to: □ Work □ Motor Vehicle Accident □ Fall injury □ Illness □ Surgery
□ No Reason □ Other (explain):_____

Please describe HOW your pain first started:_____

_____

Which of the following, if any, describe your pain?
□ Burning □ Stabbing □ Sharp □Dull □Aching □Shooting □Tender
□Throbbing

Are any of the following items related to your pain problem?
□ Numbness or loss of feeling □ Weakness □ Tingling (pins and needles) □ Muscle spasms
□ Swelling □ Change in skin color □ Bowel or bladder problems
□ Increased temperature or warmth □ Decreased temperature or coolness

Pain is Worse:
□ in the morning □ in the evening □ same all the time □Varies day to day

Pain described as:
□ constant □ frequent □ intermittent □ occasional

Do any of the following causes your pain to increase?
□ Sitting □ Standing □ Lying down □ Sneezing □ Exercising
□ Walking □Lifting □ Coughing □ Straining with bowel movement

Do any of the following cause your pain to decrease?
□ Sitting □ Standing □ Lying down □ Medications □ Exercising
□ Alcoholic Drinks □Walking □ Heat □ Cold □ Music, TV, other leisure activity □ Nothing

Does the Pain Wake you up? □ Yes □ No

(0 is no pain at all and 10 is the worst pain imaginable; like having someone hold your hand in a hot fire)

Rate your <u>current</u> pain level using a scale of 0 – 10. _____

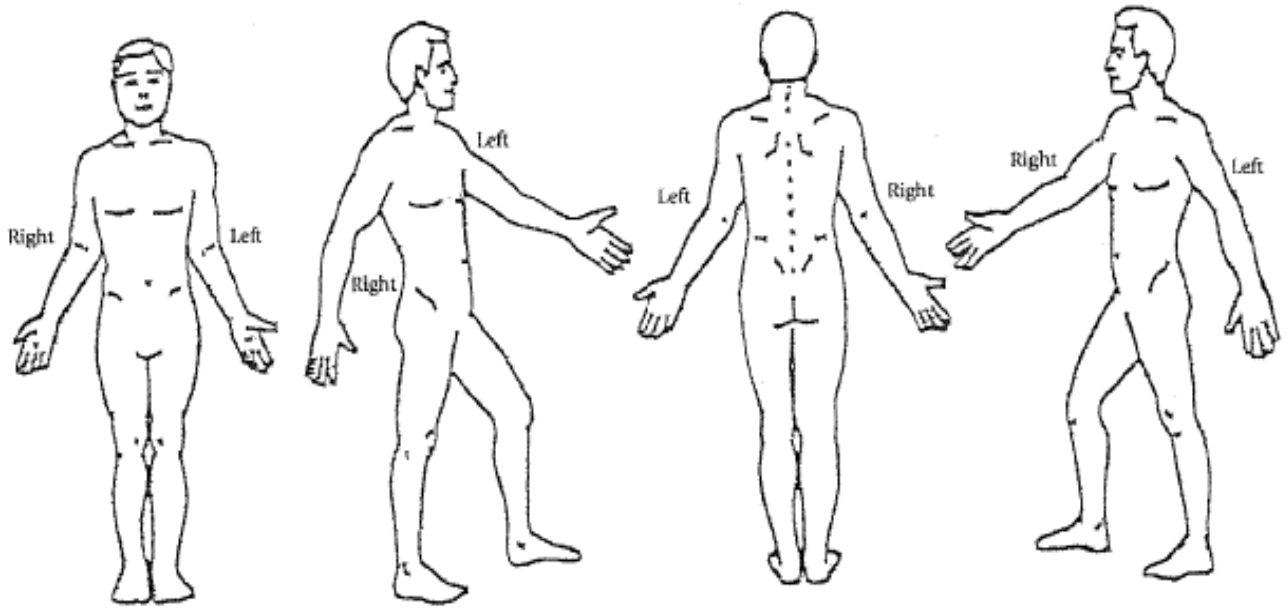
What is the least your pain gets? (0 – 10) _____

What is the worst your pain gets? (0 – 10) _____

What is your average level of pain? (0 - 10)_____

Patient Label

Please shade in on the diagram in the areas where you have pain. Mark the areas where pain begins with an 'X'.



Have you received treatment for another pain management specialist? □Yes □ No
If Yes, from which physician or facility name

_____

Previous Pain Treatments: (Check all that apply)

□ Injections □ Nerve Blocks □ Acupuncture □ TENS □ Chiropractor
□ Surgery □ Exercise □ Biofeedback □ Psychotherapy □ Massage Therapy
□ Support, Splint, Brace, Cervical Collar, Slings, Prosthesis □ Other_____

Have you tried Physical Therapy? □ Yes □ No
If yes, when and where? _____

FAMILY HISTORY

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood pressure:	_____	**Kidney Disease:**	_____	**Asthma:**	_____
Stroke:	_____	**Bleeding Tendencies:**	_____	**Tuberculosis:**	_____
Cancer:	_____	**Seizures:**	_____	**Colitis:**	_____
Emphysema:	_____	**Heart Disease:**	_____	**Anemia:**	_____
Ulcers:	_____	**Sugar Diabetes:**	_____	**Gout:**	_____
Mental Illness:	_____	**Other Serious Illness:**	_____		

Patient Label

MEDICAL HISTORY

Have you ever or do you have any of the following conditions: (check all that apply)

□ Coronary Artery Disease □ Heart Attack □ Hypertension □ Irregular Heart Beat
□ Pacemaker □ Congestive Heart Failure □ Stroke □ Dementia
□ Cancer □ Lung Disease □ Kidney Problems
□ Thyroid Disease □ Liver Disease/Jaundice □ Reflux/Peptic Ulcer Disease
□ Diabetes □ Cirrhosis □ Peripheral Vascular Disease
□ Neurological Disorder (Specify_____) □ Depression/Anxiety/Suicidal Ideation
□ Anticoagulation/Bleeding Disorder □ Arthritis (Specify_____)
□ Other Medical Conditions (Specify_____

Infections Disease – Check all that apply:

□ HIV □ Hepatitis B/ Hepatitis C □ TB □ Sexually transmitted disease □ MRSA

Are there any religious/cultural practices that the staff should know about to care for you?

□ No □ Yes, Please explain: _____

SURGICAL HISTORY

List All Surgeries: (type and date)

1.	5.
2.	6.
3.	7.
4.	8.

PSYCHOSOCIAL HISTORY

Do you or have you ever?

Smoke □ Yes □ No ____# packs/day ____# of years Quit since _____
Drink Alcohol □ Yes □ No □ History of Abuse ____# of drinks/day Quit since _____
Recreational Drug Use □ Yes □ No If yes, list:_____

Have you ever been physically abused? □ Yes □ No

Have you ever been sexually abused? □ Yes □ No

Have you ever been treated for:

□ Anger □ Depression □ Anxiety □ Suicidal Ideation

Do you work? □ Yes □ No Occupation_____
Give a brief description of your job:

_____

_____

Do you receive financial compensation because of your pain? □ Yes □ No
If yes, check all that apply: □ Workers Comp □ Private Insurance □ Disability □
Other_____

I am: □ Single □ Married □ Widowed □ Divorced/Separated
Children? □ Yes □ No If yes, how many? _____
I live: □ By myself □ With spouse □ With children □ Other:_____

Patient Label

Have you recently experienced any of the following symptoms? (Circle all that apply)

General	Fever chills night sweats weight loss fatigue/malaise
Eyes	Loss of vision photophobia blurred vision double vision
Ears, Nose & Throat	Sore throat snoring sinusitis bleeding hearing loss
Heart	Chest pain palpitations murmur congestive heart failure(last 6 months)
Lungs	Shortness of breath cough bloody sputum
Gastrointestinal	Abdominal pain nausea vomiting diarrhea constipation incontinence rectal bleeding
Genitourinary	Urinary retention sexual dysfunction frequency/urgency blood in urine pain with sex
Musculoskeletal	Muscle pain joint pain restricted movement
Skin	Rash itching
Endocrine	Diabetes thyroid disorder
Neurological	Seizures dizziness numbness weakness bowel/bladder dysfunction drowsiness
Psychiatric	Depression anxiety
Hematological	Easy bruising low platelet count anticoagulation clotting disorder
Allergy/Immunologic	Environmental allergies

Please list all medications you take including vitamins and over the counter medications

Name of Medication	Dose of the Medication	Frequency of dose	Prescribing MD

Patient Signature_____**Date**_____**Time**_____

Patient Label