

<p>Please indicate if you are taking any of the following medications.</p> <p><input type="checkbox"/> Coumadin / warfarin</p> <p><input type="checkbox"/> Ticlid / Ticlopidine</p> <p><input type="checkbox"/> Ginkgo or ginkgo balboa</p> <p><input type="checkbox"/> Any other "blood thinner"</p>	<p>Please indicate all treatments you have tried to help your pain.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th colspan="2" style="text-align: center;">Did it help?</th> </tr> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Physical Therapy</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> TENS unit</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Ultrasound</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Chiropractic</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Acupuncture</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Massage</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Biofeedback</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Psychology / counseling</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Steroid injections</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Nerve blocks</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table>		Did it help?			Yes	No	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> TENS unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Biofeedback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Psychology / counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Steroid injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Nerve blocks	<input type="checkbox"/>	<input type="checkbox"/>
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<p>Are you allergic to any medications, contrast dye, iodine, or shellfish?</p> <p><input type="checkbox"/> No, I have no allergies</p> <p><input type="checkbox"/> Yes, I am allergic to:</p> <p>_____</p>																																					

Please list all medications, herbs, and supplements that you are *currently* taking. Include all medications, not just pain medications.

Name of Drug, herb or supplement.	Strength or dosage	How many tablets at a time	How often	Total number of tablets per day	How long you have been taking it	Does it help?

Please list all medications you have taken *in the past* to treat your pain.

Name of Drug, herb or supplement.	How long did you take it?	When did you stop taking it?	Did it help your pain?

Please list all doctors that you have seen for your pain.

Doctor's Name	Hospital	Phone number	Date you were last seen

Please list all operations or surgery that you have had.

Operation	Date

Please indicate if you have any of the following medical conditions:

- | | | |
|--|--|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Muscle disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Myopathy | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Tremors | | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Adrenal gland disease | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Altered taste | <input type="checkbox"/> Thyroid disease | |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Heat intolerance | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Numbness of hands or feet | <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Kidney stones |
| | <input type="checkbox"/> Pituitary disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> COPD | <input type="checkbox"/> Loss of bladder control |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Smoking | <input type="checkbox"/> Bipolar disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Bronchitis | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Murmurs | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cancer | | <input type="checkbox"/> Sickle cell disease |
| | | <input type="checkbox"/> HIV / AIDS |

**Interventional Pain Management Clinic
Pain History Matrix and Comfort Goal**

Pain Complaint	Primary Source of Pain	Secondary source if applicable
Location of Pain Example: back, leg, neck, arm, hip, etc.		
Character: (sharp, dull, continuous, radiating, tingling, intermittent, aching, etc.)		
Aggravating factors: (It hurts when I run, bend over, sit, stand, weather, etc)		
Mitigating factors: (It feels better when I stand, sit, lay down, etc.)		
Alleviating factors: (heating pad, meds, stretching, exercise, swimming, physical therapy, etc.		
Patient Pain Comfort Goal: What pain intensity level that would allow you maximum pain relief while preserving your daily activities.		

Setting Comfort Goals: It is important that you and your medical team help establish a comfort goal. This may be a pain intensity scale from 0-10 or it may be an activity that you are working towards to make your activities of daily living bearable.

Tips on setting comfort goal

- * **Be specific:** state what you want to achieve
- * Goal should be measurable: example: I want to decrease my pain level from a 7 to 3 in 2 months.
- * Attainable: Ask yourself if the goal is reasonable, within reach.
- * **Realistic:** Is the goal realistic for you (unfortunately, depending on the underlying cause, 0/10 may not be realistic).
- * **Trackable:** tracking your progress will encourage you to keep going and reach your goal.