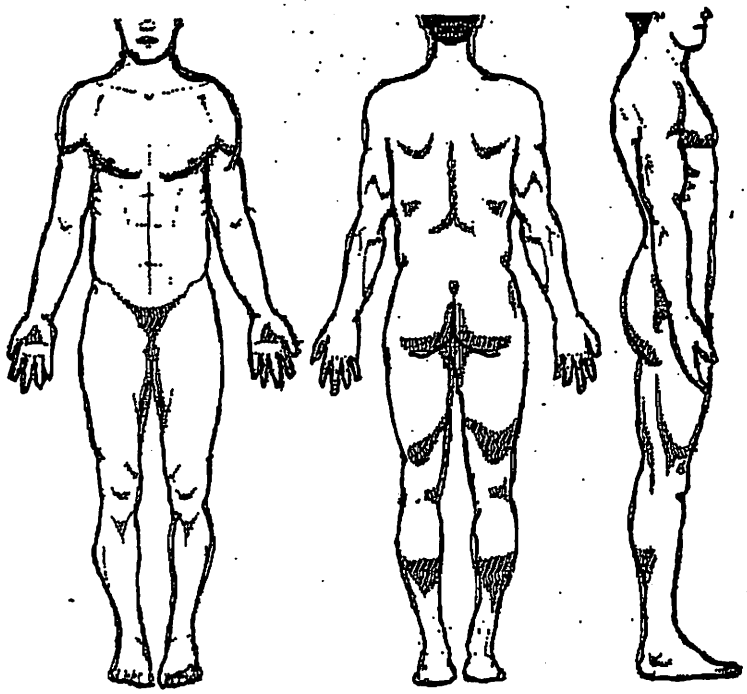
# CHRONIC PAIN EVALUATION

A) USE THE PICTURES BELOW TO SHOW THE ORIGIN OF YOUR PAIN (MARK WITH A SOLID DOT)

B) DOES THE PAIN TRAVEL OR RADIATE ANYWHERE? (MARK WITH BROKEN LINES)

C) IS THE PAIN EXTERNAL (OUTSIDE)? (MARK WITH AN "E)" OR IS THE PAIN INTERNAL (INSIDE)? (MARK WITH AN "I") OR BOTH?

D) HOW MUCH PAIN DO YOU FEEL? (MARK THE AREA(S) WITH THE APPROPRIATE NUMBER BELOW)
1-MILD 2.-UNCOMFORTABLE 3-DISTRESSING 4-VERY SEVERE 5-VERY UNBEARABLE



THE FOLLOWING INFORMATION IS MANDATORY:

1) NAME OF PHARMACY: _____

2) TELEPHONE # OF PHARMACY: _____

3) ADDRESS OF PHARMACY: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP US IN YOUR CARE.

1. DESCRIBE THE LOCATION OF YOUR PAIN:

   _____

   _____

2. DESCRIBE THE NATURE OF YOUR PAIN (SHARP, DULL, BURNING, CRAMPING, ETC.:_____

   _____

3. WHEN DID THE PAIN FIRST BEGIN?

   _____

   _____

4. WHAT MAKES YOUR PAIN BETTER?

   _____

   _____

5. WHAT MAKES YOUR PAIN WORSE?

   _____

   _____

6. DO YOU HAVE WEAKNESS? YES __ NO __ IF YES, WHERE: _____
7. DO YOU HAVE AREAS OF NUMBNESS? YES __NO __ IF YES, WHERE: _____
8. PLEASE RATE YOUR PAIN LEVEL. ZERO BEING NO PAIN AND 10 BEING EXTREME PAIN:

   TODAY: 0 1 2 3 4 5 6 7 8 9 10

   ON AVERAGE: 0 1 2 3 4 5 6 7 8 9 10

   MOST INTENSE: 0 1 2 3 4 5 6 7 8 9 10

9. DO YOU HAVE DIFFICULTY WITH YOUR BOWELS OR BLADDER? YES __ NO __
10. DO YOU HAVE DIFFICULTY FALLING ASLEEP AT NIGHT BECAUSE OF YOUR PAIN? YES __ NO __
11. DO YOU AWAKE FREQUENTLY DURING THE NIGHT BECAUSE OF YOUR PAIN? YES__ NO __
12. HOW HAS PAIN AFFECTED YOUR MOOD? (ANGRY, SAD, DEPRESSED, ETC.)_____

    _____
13. HAS YOUR APPETITE CHANGED SINCE YOU HAVE HAD THIS PAIN? INCREASED _____DECREASED _____
14. HAS THERE BEEN A CHANGE IN YOUR SEXUAL ACTIVITY? YES__ NO __
15. HOW DOES THIS PAIN AFFECT YOUR ABILITY TO FUNCTION?
    EMPLOYMENT _____
    SOCIAL LIFE _____
    RECREATION _____
    DAILY LIVING ACTIVITIES _____
16. HAVE YOU HAD ANY OF THE FOLLOWING MAJOR MEDICAL ILLNESSES?

| | |
|---|---|
| ____JOINT DISEASE/ARTHRITIS | ____STROKE |
| ____HIGH BLOOD PRESSURE | ____CANCER |
| ____LUNG DISEASE/CHRONIC BRONCHITIS | ____HIV/AIDS |
| ____SEIZURES/EPILEPSY | ____DIABETES |
| ____HEART/MAJOR BLOOD VESSEL PROBLEMS | ____THYROID DISEASE |
| ____OTHER NERVOUS SYSTEM DISEASES | ____KIDNEY DISEASE/URINARY TRACT INFECTIONS |
| ____ULCER/STOMACH PROBLEMS | ____JAUNDICE/LIVER DISEASE |
| ____DEPRESSION/ANXIETY | |

17. LIST ALL SURGERIES YOU HAVE HAD IN THE PAST: _____

    _____

    _____

18. LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING NON-PRESCRIPTION MEDICATIONS:

_____

_____

_____

19. LIST ALL DRUGS TO WHICH YOU ARE ALLERGIC OR HAVE HAD A BAD REACTION TO:

_____

_____

20. LIST ALL MEDICATIONS YOU HAVE USED TO TREAT YOUR PAIN IN THE PAST:

_____

_____

21. HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES/SURGERY TO TREAT YOUR PAIN? IF YES, PLEASE TELL US WHERE AND/OR WHEN THE PROCEDURE/SURGERY TOOK PLACE:

____CANCER SURGERY _____
____OTHER OPERATIONS FOR PAIN _____
____NERVE BLOCKS _____
____ACUPUNCTURE _____
____MANIPULATIONS/CHIROPRACTIC _____
____HYPNOSIS _____
____PHYSICAL THERAPY _____
____BED REST _____
____TRACTION _____
____PSYCHOLOGICAL COUNSELING _____
____FAMILY/MARRIAGE COUNSELING _____
____TENS (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION ) _____

22. LIST ALL DIAGNOSTIC TESTS YOU HAVE HAD:

____X RAYS ____BONE SCAN ____MYELOGRAM ____MRI ____CAT SCAN
____EMG ____NERVE CONDUCTION STUDY ____OTHER

23. MARITAL STATUS: ____SINGLE ___MARRIED ____DIVORCED ____SEPARATED ____ WIDOWED

24. NUMBER OF CHILDREN AND THEIR AGES:

_____

25. YOUR OCCUPATION: _____

26. ARE YOU CURRENTLY EMPLOYED: ____YES ____NO __FULL-TIME __PART-TIME __HOMEMAKER

27. IF YOU ARE UNEMPLOYED OR EMPLOYED PART TIME, IS THIS DUE TO PAIN? __YES __NO

28. IF RETIRED, WHEN? _____

29. DO YOU ENJOY YOUR WORK? __ALL THE TIME __MOST OF THE TIME __SOME OF THE TIME __RARELY/NEVER

30. WAS YOUR EMPLOYER HELPFUL AND UNDERSTANDING OF YOUR PROBLEM? __YES __NO

31. HAVE YOU TRIED TO RETURN TO WORK? __YES __NO

32. DID YOUR EMPLOYER ALLOW YOU TO RETURN TO WORK? __YES __NO

33. DO YOU THINK YOU CAN WORK AT YOUR REGULAR JOB? __YES __NO

34. ARE THERE ANY LITIGATION, WORKMANS' COMPENSATION OR DISABILITY ACTIONS BECAUSE OF YOUR PAIN? __YES __NO

35. DO YOU HAVE ANY HOBBIES? _____

36. DO YOU SMOKE? __YES __NO IF YES, HOW MUCH PER DAY? _____ HOW LONG? _____

37. DO YOU DRINK ALCOHOL ON A REGULAR BASIS? __YES __NO HOW MUCH? _____

Have you ever smoked? ____ How long? ____

38. DO YOU USE NOW OR HAVE YOU EVER USED ANY STREEET DRUGS? __YES __NO

39. DO YOU HAVE A RELATIVE WHO HAS HAD CHRONIC PAIN? __YES __NO
IF YES, WHOM? _____

40. WHAT DO YOU EXPECT TO GAIN FROM TREATMENT AT THE PAIN CENTER?
__COMPLETE RELIEF OF YOUR PAIN __RETURNING TO WORK WITH ABSENCE OF PAIN
__REDUCTION OF PAIN TO A LEVEL YOU CAN LIVE WITH __ RETURNING TO WORK WITH YOUR PAIN AT A TOLERABLE LEVEL
COMMENTS:
_____

BELOW YOU WILL FIND 20 DIFFERENT GROUPS OF WORDS TO DESRIBE YOUR CURRENT PAIN. IF A GROUP HAS NO WORDS TO DESCRIBE YOUR PAIN, DO NOT CIRCLE ANY WORD IN THAT GROUP. PLEASE **CIRCLE ONLY** THOSE WORDS THAT BEST DESCRIBE YOUR CURRENT PAIN AND **PLEASE DO NOT CIRCLE ANY MORE THAN ONE WORD IN EACH GROUP**

| | | | | |
|---|---|---|---|---|
| 1. FLICKERING<br>QUIVERING<br>PULSING<br>THROBBING<br>BEATING<br>POUNDING | 2. JUMPING<br>FLASHING<br>SHOOTING | 3. PRICKLING<br>BORING<br>DRILLING<br>STABBING<br>JANCINATING | 4. SHARP<br>CUTTING<br>LACERATING | 5. PINCHING<br>PRESSING<br>GNAWING<br>CRAMPING |
| 6. TUGGING<br>PULLING<br>WRENCHING | 7. HOT<br>SCALDING<br>SEARING | 8. TINGLING<br>ITCHY<br>STINGING<br>SMARTING | 9. DULL<br>SORE<br>HURTING<br>ACHING | 10. TENDER<br>TAUT<br>RASPING<br>SPLITTING |
| 11. TIRING<br>EXHAUSTING | 12. SICKENING<br>SUFFOCATING | 13. FEARFUL<br>FRIGHTFUL<br>TERRIFYING | 14. PUNISHING<br>GRUELING<br>CRUEL<br>VICIOUS<br>KILLING | 15. WRETCHED<br>BINDING |
| 16. ANNOYING<br>TROUBLESOME<br>MISERABLE<br>INTENSE<br>UNBEARABLE | 17. SPREADING<br>RADIATING<br>PENETRATING<br>PIERCING | 18. TIGHT<br>NUMB<br>SQUEEZING | 19. COOL<br>COLD | 20. NAGGING<br>NAUSEATING<br>AGONIZING<br>DREADFUL<br>TORTURING |

IT HAS BEEN FREQUENTLY OBSERVED THAT INDIVIDUALS WHO SUFFER FROM CHRONIC PAIN ALSO EXPERIENCE CHANGES IN THEIR MOODS. UNDERSTANDING THE EFFECT OF CHRONIC PAIN ON AN INDIVIDUAL'S MOOD CAN BE CRITICAL TO HELPING THEM MANAGE THEIR PAIN MORE EFFECTIVELY. PLEASE COMPLETE THE FOLLOWING QUESTIONS BY CIRCLING THAT STATEMENT WITHIN EACH ITEM THAT BEST DESCRIBES HOW YOU FEEL. CIRCLE **ONLY ONE** STATEMENT FOR EACH SET OF SENTENCES. **PLEASE ANSWER ALL OF THE QUESTIONS AND DON'T LEAVE ANY QUESTIONS UNANSWERED.**

A) I DO NOT FEEL SAD
I FEEL BLUE OR SAD
I AM BLUE OR SAD ALL OF THE TIME AND CANNOT SNAP OUT OF IT.
I AM SO SAD OR UNHAPPY THAT IT IS VERY PAINFUL.
I AM SO SAD OR UNHAPPY THAT I CANNOT STAND IT.

B) I AM NOT PARTICULARLY PESSIMISTIC OR DISCOURAGE ABOUT THE FUTURE.
I FEEL DISCOURAGE ABOUT THE FUTURE.
I FEEL I HAVE NOTHING TO LOOK FORWARD TO.
I FEEL THAT I WON'T EVER GET OVER MY TROUBLES.
I FEEL THAT THE FUTURE IS HOPELESS AND THAT THINGS CANNOT IMPROVE.

C) I DO NOT FEEL LIKE A FAILURE.
I FEEL I HAVE FAILED MORE THAN THE AVERAGE PERSON HAS.
I FEEL I HAVE ACCOMPLISHED VERY LITTLE THAT IS WORTHWHILE OR THAT MEANS ANYTHING.
AS I LOOK BACK ON MY LIFE, ALL I CAN SEE IS A LOT OF FAILURES.

D) I AM NOT PARTICULARLY DISSATISFIED.
I FEEL BORED MOST OF THE TIME.
I DON'T ENJOY THINGS THE WAY I USED TO.
I DO'T GET SATISFACTION OUT OF ANYTHING ANY MORE.
I AM DISSATISFIED WITH EVERYTHING.

E) I DON'T FEEL PARTICULARLY GULITY.
I FEEL BAD OR UNWORTH A GOOD PART OF THE TIME.
I FEEL QUITE GUILTY.
I FEEL BAD OR UNWORTHY PRACTICALLY ALL OF THE TIME NOW.
I FEEL AS THOUGH I AM VERY BAD OR WORHLESS.

F) I DON'T FEEL I AM BEING PUNISHED.
I HAVE A FEELING THAT SOMETHING BAD MAY HAPPEN TO ME.
I FEEL I AM BEING PUNISHED OR WILL BE PUNISHED.
I FEEL I DESERVE TO BE PUNISHED.
I WANT TO BE PUNISHED.

G) I DON'T FEEL DISAPPOINTED IN MYSELF.
I AM DISAPPOINTED IN MYSELF.
I DON'T LIKE MYSELF.
I AM DISGUSTED WITH MYSELF.
I HATE MYSELF.

H) I DON'T FEEL I AM ANY WORSE THAN ANYBODY ELSE IS.
I AM VERY CRITICAL OF MYSELF FOR MY WEAKNESSES OR MISTAKES.
I BLAME MYSELF FOR EVERTHING THAT GOES WRONG.
I FEEL I HAVE MY BAD FAULTS.

I) I DON'T HAVE ANY THOUGHTS ABOUT HARMING MYSELF.
I HAVE THOUGHTS ABOUT HARMING MYSELF BUT WOULD NOT CARRY THEM OUT.
I FEEL I WOULD BE BETTER OFF DEAD.
I HAVE DEFINITE PLANS ABOUT COMMITTING SUICIDE.
I FEEL MY FAMILY WOULD BE BETTER OFF IF I WERE DEAD.
I WOULD KILL MYSELF IF I COULD.

J) I DON'T CRY ANY MORE THAN USUAL.
I CRY MORE THAN I USED TO.
I CRY ALL THE TIME NOW – I CAN'T STOP.
I USED TO BE ABLE TO RY BUT NOW I CAN'T EVEN THOUGH I WANT TO.

K) I AM NO MORE IRRITATED NOW THAN I EVER AM.
I GET MORE ANNOYED OR IRRITATED NOW MORE EASILY THAN I USED TO.
I FEEL IRRITATED ALL THE TIME.
I DON'T GET IRRITATED AT ALL AT THE THINGS THAT USED TO IRRITATE ME.

L) I HAVE LOST INTEREST IN OTHER PEOPLE.
I AM LESS INTERESTED IN OTHER PEOPLE NOW THAN I USED TO BE.
I HAVE LOST MOST OF MY INTEREST IN OTHER PEOPLE AND HAVE LITTLE FEELING FOR THEM.
I HAVE LOST ALL MY INTEREST IN OTHER PEOPLE AND DON'T CARE ABOUT THEM AT ALL.

M) I MAKE DECISIONS ABOUT AS WELL AS EVER.
I AM LESS SURE OF MYSELF NOW AND TRY TO PUT OFF MAKING DECISIONS.
I CAN'T MAKE DECISIONS ANY MORE WITHOUT HELP
I CAN'T MAKE DECISIONS AT ALL ANY MORE.

N) I DON'T FEEL I LOOK WORSE THAN I USED TO.
I AM WORRIED I LOOK OLD AND UNATTRACTIVE.
I FEEL THERE ARE PERMANENT CHANGES IN MY APPEARANCE AND THEY MAKE ME LOOK UNATTRACTIVE.
I FEEL I AM UGLY OR REPULSIVE LOOKING.

O) I CAN WORK ABOUT AS WELL AS BEFORE.
IT TAKES EXTRA EFFORT TO GET STARTED AT DOING SOMETHING.
I DON'T WORK AS WELL AS I USED TO.
I HAVE TO PUSH MYSELF VERY HARD TO DO ANYTHING.
I CAN'T DO ANY WORK AT ALL.

P) I CAN SLEEP AS WELL AS USUAL.
I WAKE UP MORE TIRED IN THE MORNING THAN I USED TO.
I WAKE UP 1-2 HOURS EARLIER THAN USUAL AND FIND IT HARD TO GET BACK TO SLEEP.
I WAKE UP EARLY EVERY DAY AND CAN'T GET MORE THAN 5 HOURS SLEEP.

Q) I DO NOT GET MORE TIRED THAN USUAL.
I GET MORE TIRED IN THE MORNING THAN I USE TO.
I GET TIRED FROM DOING ANYTHING.
I GET TOO TIRED TO DO ANYTHING.

R) MY APPETITE IS NO WORSE THAN USUAL.
MY APPETITE IS NOT AS GOOD AS IT USED TO BE.
MY APPETITE IS MUCH WORSE NOW.
I HAVE NO APPETITE AT ALL ANYMORE.

S) I HAVE NOT LOST MUCH WEIGHT, IF ANY, LATELY.
I HAVE LOST MORE THAN 5 POUNDS.
I HAVE LOST MORE THAN 10 POUNDS.
I HAVE LOST MORE THAN 15 POUNDS

T) I AM NO MORE CONCERNED ABOUT MY HEALTH THAN USUAL.
I AM CONCERNED ABOUT ACHES AND PAINS, UPSET STOMACH, CONSTIPATION OR OTHER UNPLEASANT FEELINGS IN MY BODY.
I AM SO CONCERNED WITH HOW I FEEL OR WHAT I FEEL THAT IT'S HARD TO THINK ABOUT ANYTHING ELSE.
I AM COMPLETELY ABSORBED IN HOW I FEEL.

U) I HAVE NOT NOTICED ANY RECENT CHANGE IN MY INTEREST IN SEX.
I AM LESS INTERESTED IN SEX THAN I USED TO BE.
I AM MUCH LESS INTERESTED IN SEX NOW.
I HAVE LOST INTEREST IN SEX COMPLETELY.

NAME: _____ DATE: _____

# MEDICATION RECONCILIATION RECORD

(PROVIDED BY PATIENT)

(INCLUDE: PRESCRIPTION, OVER-THE-COUNTER MEDICINES, HERBALS, VITAMINS, NUTRITIONAL SUPPLEMENT, COMPLIMENTARY AND ALTERNATIVE THERAPY, ETC.)

| MEDS/VITAMINS SUPPL/NAME | DOSE MG/MCG HOW MANY? | FREQ. (EX:2X DAY) | REASON FOR TAKING THIS MED | LAST DOSE TAKEN | RESUME UPON DISCHARGE (M.D.-PLS CK) |
|---|---|---|---|---|---|
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# INNOVATIVE PAIN TREATMENT SOLUTIONS

*WHEN YOU HAVEN'T GOT TIME FOR THE PAIN*

**DATE:** _____ **THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY**

NAME: _____ DOB _____

ADDRESS: _____ CITY/ST/ZIP _____

PHONE: _____ SS #: _____ MALE/FEMALE (PLEASE CIRCLE)

ALTERNATE PHONE #: _____ SPOUSE'S NAME: _____

CLOSEST RELATIVE NOT LIVING WITH YOU: _____

PHONE #: _____ RELATIONSHIP: _____

**REFERRING PHYSICIAN**

NAME OF DOCTOR THAT REFERRED YOU TO DR. WEINER: _____ PHONE #: _____

PREVIOUS PRESCRIBING PAIN MEDICINE PHYSICIAN: _____

PHONE #: _____ CITY: _____

**BILLING INFORMATION**

PRIMARY INSURANCE: _____ ID #: _____

PHONE #: _____ SUBSCRIBER'S NAME: _____

FOR OUR MEDICARE PATIENTS, WHAT IS YOUR SUPPLEMENTAL INSURANCE?: _____

**EMPLOYER INFORMATION**

NAME OF PATIENT'S EMPLOYER: _____ PHONE #: _____

NAME OF SUBSCRIBER'S EMPLOYER: _____ PHONE #: _____

## (THE FOLLOWING REQUESTS ARE NECESSARY DUE TO NEW MEDICARE RULES-2012)

RACE:
- WHITE
- AMERICAN INDIAN/ALASKA NATIVE
- ASIAN
- BLACK OR AFRICAN AMERICAN
- HISPANIC OR LATINO
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- DECLINE TO STATE ___

ETHNICITY:
- HISPANIC OR LATINO
- NOT HISPANIC OR LATINO
- DECLINE TO STATE _____

Preferred Language: _____