

Name: \_\_\_\_\_

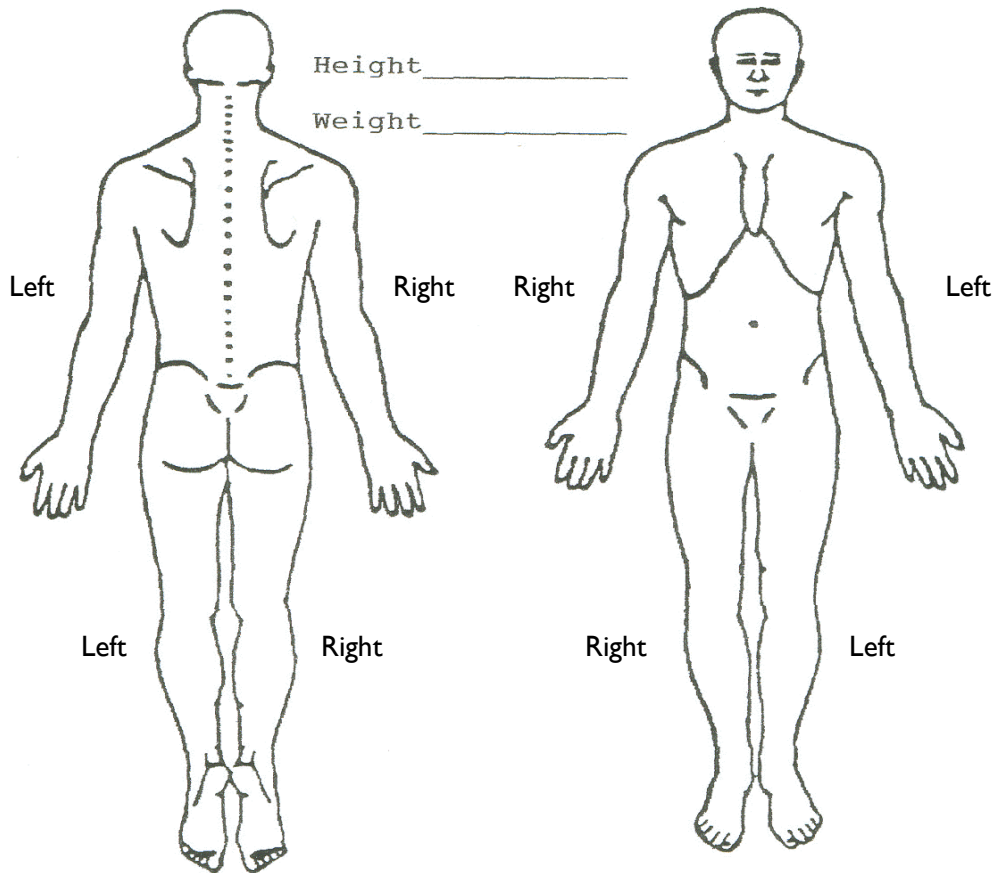
Date: \_\_\_\_\_

### CHRONIC PAIN EVALUATION

Please help us understand your pain by completing this drawing:

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 a broken line)



Please list your areas of pain from most painful to least painful:

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

**Please help us understand your pain by answering the following questions:**

1) When did your pain start? \_\_\_\_\_

2) Is your pain aggravated by work?  yes  no  
If so, how? \_\_\_\_\_

3) Have you had any other injuries in the past that were **not** work-related? If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

4) Have you received a medical discharge from the Armed Forces?  yes  no

**5) Please rate your pain level on the scale below:**

0 = no pain

10 = worst pain

|               |   |   |   |   |   |   |   |   |   |   |    |
|---------------|---|---|---|---|---|---|---|---|---|---|----|
| Now:          | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 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 |

6) My pain is **worse** when I (please "X" all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Cough or sneeze | <input type="checkbox"/> Breathe In       |
| <input type="checkbox"/> Sit             | <input type="checkbox"/> Bend my low back |
| <input type="checkbox"/> Bend my neck    | <input type="checkbox"/> Turn my head     |
| <input type="checkbox"/> Walk            | <input type="checkbox"/> Lift             |
| <input type="checkbox"/> Push            | <input type="checkbox"/> Pull             |
| <input type="checkbox"/> Stand           | <input type="checkbox"/> Other: _____     |

7) What makes your pain **better**? \_\_\_\_\_

8) Do you have **weakness**?  yes  no  
Where? \_\_\_\_\_

9) Do you have areas of **numbness** or **tingling**?  yes  no  
Where? \_\_\_\_\_

10) Do you have difficulty controlling your bowels or bladder?  yes  no

11) Have you had any of the following procedures done to treat your pain? (Please "X" all that apply):

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> physical therapy            | <input type="checkbox"/> bed rest     |
| <input type="checkbox"/> psychological counseling    | <input type="checkbox"/> ice          |
| <input type="checkbox"/> epidural steroid injections | <input type="checkbox"/> heat         |
| <input type="checkbox"/> facet joint injections      | <input type="checkbox"/> nerve blocks |
| <input type="checkbox"/> trigger point injections    | <input type="checkbox"/> acupuncture  |
| <input type="checkbox"/> chiropractic therapy        | <input type="checkbox"/> surgery      |

- anti-inflammatory medication
- joint injection(s)
- TENS (transcutaneous electrical nerve stimulation)
- traction
- steroids

12) Have any of the above-listed procedures decreased your pain?  
 yes  no

13) List all medications you have used in the past to treat your pain.

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14) List all diagnostic tests you have had and specify which body part was tested:

- MRI \_\_\_\_\_  Bone Scan \_\_\_\_\_
- X-ray \_\_\_\_\_  CT scan \_\_\_\_\_
- Myelogram \_\_\_\_\_  Discogram \_\_\_\_\_
- EMG/nerve conduction studies \_\_\_\_\_
- Other \_\_\_\_\_

15) Have you had any of the following medical illnesses?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> Peptic Ulcer Disease | <input type="checkbox"/> Gastritis   |
| <input type="checkbox"/> Anxiety                       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Shingles  |
| <input type="checkbox"/> Pulmonary Embolus             | <input type="checkbox"/> Pancreatitis         | <input type="checkbox"/> Syphilis  |
| <input type="checkbox"/> Major Blood Vessel            | <input type="checkbox"/> Thyroid Disease      | <input type="checkbox"/> Lupus   |
| <input type="checkbox"/> Congestive Heart Failure      | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Asthma  |
| <input type="checkbox"/> Bleeding Tendency             | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Peripheral Vascular Disease   |
| <input type="checkbox"/> Abnormal Heart Rhythm         | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> High Cholesterol  |
| <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Parkinson's Disease   |
| <input type="checkbox"/> Interstitial Cystitis.        | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Restless Leg Syndrome   |
| <input type="checkbox"/> Chronic Bronchitis            | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Psoriasis   |
| <input type="checkbox"/> Rheumatoid Arthritis          | <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Migraine Headaches  |
| <input type="checkbox"/> Stroke                        | <input type="checkbox"/> Chicken Pox          | <input type="checkbox"/> Tension Headache  |
| <input type="checkbox"/> Kidney Stones                 | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Carpal Tunnel Syndrome—[ <input type="checkbox"/> right [ <input type="checkbox"/> left |
| <input type="checkbox"/> Other Nervous System Diseases | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Deep Venous Thrombosis  |
| <input type="checkbox"/> Urinary Tract Infections      | <input type="checkbox"/> Meningitis           | <input type="checkbox"/> Endometriosis   |
| <input type="checkbox"/> Seizures/Epilepsy             | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Sleep Apnea   |
| <input type="checkbox"/> Cancer. What type? _____      | <input type="checkbox"/> Radiation            | <input type="checkbox"/> Chemotherapy  |
| <input type="checkbox"/> Whiplash                      | <input type="checkbox"/> Concussion           | <input type="checkbox"/> Peripheral Neuropathy   |

16) Have you had any major illnesses that required hospitalization?  yes  no  
Describe: \_\_\_\_\_

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17) Have you had chronic exposure to any toxins? \_\_\_\_\_

18) List all surgeries you have had in the past: \_\_\_\_\_

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19) List all medications you are currently taking, including nonprescription medications – continue on the back of this page if necessary.

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20) List all drugs to which you are allergic: \_\_\_\_\_  
\_\_\_\_\_

21) List all drugs to which you have had a bad reaction: \_\_\_\_\_  
\_\_\_\_\_

22) Have you ever used prescribed controlled drugs before? \_\_\_\_\_

23) Have you ever been to a pain doctor before? \_\_\_\_\_

24) Do you have a past history of chemical/substance abuse, including alcohol, illicit and/or illicit drugs? \_\_\_\_\_

### REVIEW OF SYSTEMS

25) Please list any problems that you **NOW HAVE** with the following body systems:

Ear/Nose/Throat: ( ) Denied \_\_\_\_\_

Eyes: ( ) Denied \_\_\_\_\_

Lungs: ( ) Denied \_\_\_\_\_

Liver: ( ) Denied \_\_\_\_\_

G-I Tract (Stomach, Intestines, Bowels, Etc.): ( ) Denied \_\_\_\_\_

Kidney/Bladder: ( ) Denied \_\_\_\_\_

[Women] Reproductive System: ( ) Denied \_\_\_\_\_

Skin: ( ) Denied \_\_\_\_\_

Neurological: ( ) Denied \_\_\_\_\_

Heart/Circulation: ( ) Denied \_\_\_\_\_

Psychological: ( ) Denied \_\_\_\_\_

### FAMILY HISTORY:

26) Has anyone in your family experienced similar pain? [ ] yes [ ] no

### SOCIAL HISTORY:

27) What is your marital status?  
[ ] single [ ] married [ ] divorced [ ] separated [ ] widowed

28) Do you have children? [ ] yes [ ] no How many? \_\_\_\_\_  
Ages: \_\_\_\_\_

29) Do you smoke? [ ] yes [ ] no How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

30) Do you drink alcohol on a regular basis? [ ] yes [ ] no  
If yes, how many drinks per day of what type? \_\_\_\_\_

31) Do you use any street drugs? [ ] yes [ ] no

32) What is your highest level of education? \_\_\_\_\_

33) Has pain affected your:

- |                 |                              |                             |
|-----------------|------------------------------|-----------------------------|
| Sleep           | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Exercise        | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Mood            | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Appetite        | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Sexual Activity | <input type="checkbox"/> yes | <input type="checkbox"/> no |

### OCCUPATIONAL HISTORY:

34) Are you currently employed?  no  full time  part time  homemaker  
 retired

35) What is your occupation? \_\_\_\_\_

36) If you are unemployed or employed part time, is this due to your pain?  yes  no

37) Is there currently any personal injury litigation due to your pain?  yes  no

38) Are you receiving any disability payments due to your pain?  yes  no  
If so, what type ("X" all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Social Security | <input type="checkbox"/> State Disability     |
| <input type="checkbox"/> Private         | <input type="checkbox"/> Workers Compensation |

39) If female, is there any way you could be pregnant?  yes  no

40) Are you currently receiving **chiropractic physical therapy**?  yes  no  
If yes, where and how many days per week? \_\_\_\_\_

41) Are you currently receiving **physical therapy**?  yes  no  
If yes, where and how many days per week? \_\_\_\_\_

42) Have you had any **work-related** injuries in the past?  yes  no

43) Is your current pain due to a **work-related** injury?  yes  no

44) Who is your primary care physician? \_\_\_\_\_

45) Which doctor referred you to us? \_\_\_\_\_

46) If you were not referred, how did you hear about us? \_\_\_\_\_

47) Do you have an Advance Healthcare Directive?  Yes  No  
If yes, please provide us with a copy

## CERTIFICATION

I certify that I have answered truthfully all the questions, and have not knowingly withheld any information concerning any of the above problems, either past or present.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**BECAUSE DR. VELIZ IS A SOLO MEDICAL PRACTITIONER WITH NO OTHER MEDICAL DOCTORS, PHYSICIAN ASSISTANTS OR NURSE PRACTITIONERS, HE CANNOT DO ANY MORE OPIATE OR NARCOTIC MEDICATION MANAGEMENT.**

**DR. VELIZ WILL MAKE RECOMMENDATIONS FOR YOUR PRIMARY CARE PHYSICIAN TO FILL YOUR OPIATES OR NARCOTICS.**

I agree that Dr. Jose Veliz will **not** provide **narcotic medication management** for me. I agree that my narcotic medications will be filled by my primary care physician OR other prescribing specialist not including Dr. Jose Veliz.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

**THANK YOU!**

\_\_\_\_\_  
Signature of Reviewing Physician

\_\_\_\_\_  
Date